The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 7 September, 2017 at 8.45am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies – A McMenemy**		J Ord	To Note	8.45
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	8.45
3.	**Announcements**		J Ord	To Note	8.45
4.	**Minutes of the previous meeting**				
	4.1 Thursday 3 August 2017	Enclosure 1	J Ord	To Approve	8.45
	4.2 Action Sheet 3 August 2017	Enclosure 2	J Ord	To Action	8.50
5.	**Patient Story**		L Abbiss	To Note & Discuss	8.55
6.	**Chief Executive's Overview Report**	Enclosure 3	D Wake	To Discuss	9.05
7.	**Safe and Caring**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 4	D Wulff	To note assurances & discuss any actions	9.15
	7.2 Audit Committee Exception Report	Enclosure 5	R Miner	To note assurances & discuss any actions	9.25
	7.3 Chief Nurse Report	Enclosure 6	S Jordan	To note assurances & discuss any actions	9.35
	7.4 Nurse/Midwife Staffing Report	Enclosure 7	S Jordan	To note assurances & approve recommendation	9.45
	7.5 Annual Infection Prevention and Control Report	Enclosure 8	E Rees	To discuss and note assurances	9.55

	7.6 Guardian of Safe Working Report	Enclosure 9	B Elahi	To discuss	10.05
	7.7 Speak Up Guardian Report	Enclosure 10	C Love-Mecrow/ D Eaves	To discuss	10.15
8	**Responsive and Effective**				
	8.1 Complaints Report	Enclosure 11	S Jordan	To discuss	10.25
	8.2 Learning from Deaths Policy	Enclosure 12	P Harrison	To approve	10.35
	8.3 Winter Plan Presentation	Enclosure 13	N Hobbs	To note assurances	10.45
	8.4 Finance and Performance Committee Exception report	Enclosure 14	J Fellows	To note assurances & discuss any actions	10.55
	8.5 Performance Report	Enclosure 15	P Bytheway	To note assurances & discuss any actions	11.15
	8.6 Cost Improvement Programme and Transformation Overview Report	Enclosure 16	P Taylor	To note assurances & discuss any actions	11.35
9.	**Well Led**				
	9.1 Corporate Risk Register and Assurance Report	Enclosure 17	G Palethorpe	To note assurances	11.45
	9.2 Corporate Calendar Report	Enclosure 18	G Palethorpe	To approve	11.55
	9.3 Annual Plan Quarterly Monitoring Report	Enclosure 19	L Peaty	To note assurances	12.00
	9.4 Smoke Free update	Enclosure 20	L Abbiss	To discuss and agree actions	12.15
	9.5 Digital Trust Committee Exception Report	Enclosure 21	A Becke/ J Dale	To note assurances & discuss any actions	12.25
10.	**Any other Business**		J Ord		12.35
11.	**Date of Next Board of Directors Meeting** 9.30am 5 October, 2017 Clinical Education Centre		J Ord		12.35

12.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord		12.35

Quorum: One Third of Total Board Members to include One Executive Director and One Non Executive Director

Enclosure 1

The Dudley Group NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 3rd August, 2017 at 9am in the Clinical Education Centre.

Present:

Diane Wake, Chief Executive
Jenni Ord, Chairman
Richard Miner, Non-Executive Director
Julian Atkins, Non-Executive Director
Paul Harrison, Medical Director
Siobhan Jordan, Interim Chief Nurse
Paul Bytheway, Chief Operating Officer

In Attendance:

Amanda Howes, PA
Glen Palethorpe, Director of Governance/Board Secretary
Mark Stanton, Chief Information Officer
Dr Mark Hopkin, Associate Non-Executive Director
Liz Abbiss, Head of Communications
Richard Price, Deputy Director of Finance – Performance
Lisa Peaty, Assistant Director Strategy and Performance

17/078 Note of Apologies and Welcome
9am

Andrew McMenemy, Director of HR
Paul Taylor, Director of Finance and Information
Doug Wulff, Non-Executive Director
Ann Becke, Non-Executive Director
Jonathan Fellows, Non-Executive Director

17/079 Declarations of Interest
9:01am

The Medical Director's standing declaration was noted and it was confirmed that this did not conflict with any items on the Agenda requiring any decision.

Dr Mark Hopkin confirmed that he was a GP and Clinical Lead at the CCG as it was confirmed that this did not conflict with any items on the Agenda requiring a decision.

There were no other declarations of interest.

17/080 Announcements
9:01am

The Chairman confirmed that the Trust has two Executive Director vacancies namely Chief Nurse and Director of Finance for which the Trust is to commence recruitment processes and the advertisements should be placed by the end of this week or by Monday of next week

17/081 Minutes of the previous Board meeting held on 6 July, 2017
(Enclosure 1)
09:03am

- The Chief Operating Officer requested an amendment to Page 4 final sentence to read 'that the incident relates to Infection Control'.

- The Chief Operating Officer requested an amendment to Page 8 to read that formal assurance from an external review is still ongoing with the final review still awaited.

- The Chief Operating Officer requested an amendment to page 10 with reference to 'a mobile CT scanner will be on site from 6th July and it was now forecast the target would be reached by September 2017'.

The minutes of the previous meeting subject to the above agreed minor amendments were agreed by the Board as a correct record of the meeting and could be signed by the Chairman.

17/082 Action Sheet, 6 July, 2017 (Enclosure 2)
09:06am

The Board noted that item 17/074.5 'Mortality Report' draft policy had been presented to CQSPE with the formal Policy due for submission to the September Trust Board.

All other items on the list were either complete or for a future meeting.

17/083 Patient Story
09:09am

The featured patient, a 57 year old lady, who had been diagnosed with Multiple Sclerosis and had sustained a fall resulting in a broken ankle. The Board heard that the patient's stay in hospital was for 6 weeks and noted that overall the experience was good. The patient had a lot of praise for the care provided, particularly from one of the Doctors.

The Board noted that that the patient had an issue with distributing refreshments between one ward area and another where they are located off the same corridor. Also she described a noticeable inconsistency between regular staff and agency staff in understanding ward processes which she thought could potentially cause delays in discharging patients home. She also raised an issue with one interaction with a member of staff whose attitude was poor.

The Head of Communications confirmed, upon conclusion of the story, that all the information had been shown to the Directorate Manager and Associate Chief Nurse to enable any required improvements.

The Chief Nurse confirmed to the Board that the Associate Chief Nurse had met with the patient and had visited the patient daily. Actions are proceeding with the layout of the nursing stations and staff understanding of ward processes.

The Chief Executive expressed concern relating to the 6 weeks stay in hospital and whether discharge could have been expedited. The Chief Executive assured the Board that the Trust is addressing agency staff use as the Trust recognises that substantive staff give extra value to patients.

The Chief Executive noted that in relation to refreshments the Deputy Director of Finance will liaise with Interserve about the issue of ward hand overs.

The Chairman commented upon the recent quality visit to the Vascular ward, the findings of which triangulated with this patient's story.

The Chief Nurse assured the Board that since the patient story was documented the ward's use of agency staff has significantly reduced.

Mr Atkins, Non-Executive Director, sought assurance from Board colleagues about the response to the attitude of the staff member raised within the story. The Head of Communications confirmed that the member of staff identified in the story had been spoken to and had received additional training and also a Disciplinary letter in line with Trust Policy.

The Chairman and Board noted the story.

17/084 Chief Executive's Overview Report (Enclosure 3)
9:30am

The Chief Executive presented her report, given as Enclosure 3.

The Board noted the positive trend of the Friends and Family Test.

The Chief Nurse drew to the Board's attention the response rates within Table 1, in particular within Community and Outpatients, with Community showing an improved result of 2.1% (June'17) from a rate of 1.1% (July'16). Unvalidated figures show a further improvement with an expected rate of 5.2% (July'17). The Board commended the Community on its improved response rates.

The Chairman referred to the 'Children's Welcome Booklet Design Competition' contained within the report and commended this work.

The Chairman and Board noted the full details of the report.

17/085 Patient Safety and Quality

17/085.1 Clinical Strategy (Enclosure 4)
9:35am *Lisa Peaty, Assistant Director Strategy and Performance joined the meeting*

Dr Harrison, Medical Director presented the Clinical Strategy Report, given as Enclosure 4.

The Board heard that the strategy had been discussed at the recent Clinical Quality, Safety and Patient Experience Committee. It reflected the necessity of adopting a flexible approach as a consequence of the changing environment affecting the NHS and the Trust.

Mr Miner, Non-Executive Director referred to the external drivers on the Strategy, in particular the MCP and the Trust's ability through this Strategy to mitigate against any downside risks with the possibility of improving the Trust's private income. The Trust's current position compared against the model hospital

metrics was low for this opportunity. The Finance and Performance Committee had asked that such options be further explored. One possibility was to enable consultants to use Trust facilities for their private work which could assist with the wider absorption of Trust overhead costs.

Ms Peaty assured the Board that the strategy is underpinned by the Annual Planning process, with the Annual Plan detailing the responsibility for annual goal delivery in line with the Trust's strategic direction.

The Chairman confirmed that the current annual business plan process is monitored quarterly and advised the Board that an early draft of next year's plan will be presented in late Autumn.

The Chairman commented that some reference to the Trust's educational provision within the Strategy would be helpful along with information on associated research and clinical governance processes. The Chair also reminded the Board that a number of supporting existing strategies such as the estates strategy are in need of a refresh within the next year. It was though positive that links had been made with these supporting strategies.

The Medical Director alerted the Board to the opportunities to collaborate on Clinical Services within the STP, which could have an impact on local clinical services in the future.

The Chairman asked that the Clinical Strategy be amended to include a focus on Research and Innovation before being launched. Also that it should be made clear how the delivery of the strategy would be monitored e.g., through the annual business planning goals and the identification of leads.

The Chairman also requested the inclusion of the potential commercial opportunities within the yet to be defined marketing strategy.

The Board **approved** the strategy subject to the discussed enhancements.

The Strategy would be launched without further need for Board approval.

The quarterly monitoring of the annual plan delivery report be clearly linked to the clinical strategy.

17/085.2 Pathology Outline Business Case (OBC) (Enclosure 5)
09:55am

The Chief Executive presented her report as Enclosure 5.

The Board were advised that there will be critical and robust engagement with staff about this development and staff will be included in the clinical model development which follows from this stage of the process.

The Board noted that the capital expenditure required was in the region of £5-9m, with a potential of external funding although this had yet to be confirmed.

The Chairman referred the Board to the projected timeframe for project delivery and that there is requirement for a transitional phase. The Board was assured that the final solution would only be agreed if the proposed service was 'fit for purpose' and the Board **agreed** that in making its final decision it would not governed unduly by unrealistic timeframes. Whilst, the OBC set out a preferred option of a single hub with distributed Essential Service Laboratories (ESL) the Board acknowledged that the ESL model in each Trust must fit with the respective clinical strategy and service that each individual site will need to deliver.

The Chairman acknowledged that there is a requirement to begin recruiting leadership roles to drive the project forward but there would be a need to clarify who would be involved in this process.

The importance of the Clinical Reference Group in assuring the quality of service and that optimum service levels would be in place was stressed. To progress to the next stage the Board was advised that the Trust will need to agree to funding its proposed share of £92,500 (costs to Oct'17). This was **agreed**.

The Deputy Director of Finance & Performance reminded the Board that the Full Business Case development will require a significant amount of due diligence to support the final costings.

The Board **agreed** the recommendations in the paper subject to the development of the detailed transitional operational model and a Full Business Case being provided with sufficient time for adequate consideration by the Board. The Chair also asked that the work continues with the engagement of all stakeholders especially the staff, in respect of the next phase and that management ensure that everyone is included within its communication plans. The Project team need to be advised of the Board's decision.

17/085.3 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 6) 10:25am

Mr Palethorpe presented on behalf of the Committee Chair, the Clinical Quality, Safety and Patient Experience Committee Exception Report, given as Enclosure 6.

The Board noted the following key areas from the Committee meeting:

Compliance with alerts in particular the Patient Safety Agency Alert in respect of Naso Gastro Tube placements which has seen an improvement.

The Board was updated on the actions being taken in respect of compliance with safeguarding training and its support from NHSI to strengthen Trust processes.

The Board noted that the Committee had been made aware of the work planned to secure increased resources to deal with the Ophthalmology service demands.

The Board acknowledged that the Committee had endorsed the Trust's updated Clinical Strategy.

The Board **agreed** with the Committee endorsement of the Executive Management's decision to undertake the Duty of Candour conversation earlier in the SI process at the point the Trust Executive conclude the SI Report.

17/085.4 Chief Nurse Report – Infection Control (Enclosure 7)
10:30am

The Chief Nurse presented her report, given as Enclosure 7.

The Board were advised that the 'Infection Control Mandatory Training' had seen an improvement in compliance. This was commended by the Board.

The Board **noted** the report and the current position on infection control in respect of C-Diff.

17/085.5 Nurse/Midwife Staffing Report (Enclosure 8)
10:31am

The Chief Nurse presented the monthly Nurse/Midwife Staffing Report given as Enclosure 8.

The Chief Nurse reported upon the Care Hours per Patient Day (CHPPD) relating to the position of qualified and unqualified staff within the Trust and the actions to recruit an increased substantive workforce.

The Board noted phases 1-5 of the staffing review and heard that following the completion of phase 1 the Chief Nurse and Human Resources Director have drawn up an implementation plan. The Board **agreed** to the increased resources required for increasing the substantive surgery nursing workforce.

The Board were advised of a Recruitment Day scheduled for August and the Chief Nurse advised of plans to support reduced timescales to provide contracts for recruits.

The Chairman **noted** the good progress being made and further reiterated the Board support for the increase in the substantive surgery nursing workforce which itself had been endorsed by the Finance and Performance Committee.

17/086 Finance and Performance

17/086.1 Finance and Performance Committee Exception Report (Enclosure 9)
10.39am

Mr Price – Deputy Director of Finance & Performance presented on behalf of the Committee Chair, the Finance and Performance Exception Report given as Enclosure 9.

Mr Price reported to the Board that the Trust has met its financial target for quarter 1, confirming that the £1.286m STF monies is expected from NHS Improvement.

The Board were asked to note the risks to the 2017-18 financial forecast and the steps being taken to address these. The Board noted these risks were within the Trust's BAF.

The Board discussed a potential future Board Workshop topic relating to Model Hospital comparative information which would identify further opportunities for both income generation and efficiencies.

Mr Price reported that the proposed increase in staffing had been discussed and approved as part of the last item presented by the Chief Nurse.

17/086.2 Performance Report (Enclosure 10)
10:42am

The Chief Operating Officer presented the Performance Report given as Enclosure 10.

The Board noted that the A&E Target has seen an improvement in June to 93.5%.

The Chief Operating Officer commented upon the daily rise in admissions from 300 patients per day compared to 270 patients previously. Most of the increase was due to ambulance arrivals. However, the Board were reminded of the work being undertaken within the Trust on patient flow work, discharge planning and the bed utilisation work.

The Board were alerted to the provisional performance figures for Cancer 62 day wait for June being at only 78.1% with this target unlikely to be met in Quarter 1.

The Chief Operating Officer reported that the Diagnostic Performance target continues to improve in line with the Trust plan.

The Board commented upon the disappointing Mandatory Training levels and were assured that this is being addressed particularly with the transition to a more substantive workforce.

The Chief Operating Officer advised the Board of the Urgent Care Centre work being undertaken to integrate the Urgent Care Centre and the ED facility which will improve flow and absorb some of the increased pressure on ED.

17/087 Any Other Business
10:47am

There were no other items of business to report and the meeting was closed.

17/088 Date of next meeting

The next Board meeting will be held on Thursday 7th September, 2017, at 09:30am in the Clinical Education Centre.

Signed……

Date……..

Enclosure 2

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 3 August 2017

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
17/041.7	Corporate Risk Register and Assurance Report	The Executive Team to consider the inclusion of the new Apprenticeship levy on the Risk Register.	ET	6/7/17 6/9/17	Corporate Risk Register Report to be presented at the next Board. Deferred to September Board due to timings. On Agenda
17/074.4	Workforce Committee	Improvements to be seen in relation to timescales for shortlisting for interview by the next Workforce Committee meeting.	AM	26/9/17	
17/052.3	Complaints and Claims Report	Future reports to contain correlation with incidents and examples of learning.	GP	7/9/17	The Complaints Report on the Agenda has been redesigned to draw out learning.
17/063.5	Guardian of Safe Working Report	Assurance to be presented to the Board around the exception reporting process in 3 months time.	BE	7/9/17	Information included within the report on the Agenda.
17/063.6	Trust Annual Plan Objectives 2017-18	Appropriate maternity elements specific to Dudley to be included in the Annual Plan. Text regarding the MCP to be amended in light of timescales.	LP	7/9/17	Wording has been added to the Plan.
17/074.6	Health, Safety and Fire Assurance Report	The full result of the independent review to be reported to the regulators and the Board.	PB	7/9/17	Specific fire safety update on the Agenda.
17/063.3	Research and Development Report	Research and Development Strategy to be produced and presented to Board. R&D newsletter to be made available to Community staff.	JN JN	7/12/17 7/12/17	

17/063.9	Organ Donation Report	Tissue and organ donation data to be included in future OD Annual Reports. General Practice to be included in the Organ Donation week arrangements for September. The Chief Nurse to join the Organ Donation Committee. NHSBT to facilitate contacts with the Tissue Donation team.	JN/RE/RU JN/RE/RU SJ	7/12/17 Sept 17 November Donation Committee Meeting	Dr Sonksen is rolling our communications to all 54 GP practices in the CCG. The NHSBT Communications Team have provided video extracts and Organ Donation leaflets to be delivered to each of these practices to be available to all practices and their patients during Organ Donation week.
17/085.1	Clinical Strategy	The Strategy should be launched subject to recommended changes without further reference to the Board.	PH	Sept 17	Meeting to finalise changes taking place 4th September 2017.
17/085.1	Clinical Strategy	The quarterly monitoring of the annual plan delivery report be clearly linked to the Clinical Strategy.	LP	Sept 17	The link is included within the report.
17/085.2	Pathology Outline Business Case	The Board agreed the recommendations in the paper subject to the development of the detailed transitional operational model and a Full Business Case being provided with sufficient time for adequate consideration by the Board. The Chair also asked that the work continues with the engagement of all stakeholders especially the staff, in respect of the next phase and that management ensure that everyone is included within its communication plans. The Project team need to be advised of the Board's decision	DW/PB	Sept 17	Meetings are being held with staff groups, along with emails to support information after every Pathology Board meeting. The divisional team are collating an issues log to ensure that all concerns and feedback is captured.

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 7th September 2017

TITLE:	**Chief Executive Board Report**		
AUTHOR:	**Diane Wake, Chief Executive**	**PRESENTER**	**Diane Wake, Chief Executive**
CORPORATE OBJECTIVE: SO1, SO2, SO3, SO4, SO5, SO6			

SUMMARY OF KEY ISSUES:

- Executive Team – Future Changes
- CQC Inspection Planning
- Capital Projects Progress
- Performance Challenges
- Visits and Events
- Fire Safety Update
- Local News
- Regional NHS News

IMPLICATIONS OF PAPER:

RISK	**No**		**Risk Description:**
	Risk Register: No		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details: Effective, Responsive, Caring**
	Monitor	**No**	**Details:**
	Other	**No**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		Y	**Y**

RECOMMENDATIONS FOR THE BOARD: The Board are asked to note and comment on the contents of the report

The Dudley Group
NHS Foundation Trust

Chief Executive's Report – Public Board – September 2017

This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and a highlight a number of items of interest.

Items below are not reported in any order of priority.

Executive Team – Future Changes

New Director of Strategy and Business Planning, Natalie Younes, joins the Trust on 21st September, 2017.

Operational Medical Director, Julian Hobbs, joins the Trust on 1st October, 2017.

Recruitment process in progress for the Executive Chief Nurse and Director of Finance. Interviews to be held during September and October 2017.

CQC Inspection Planning

The month of August has seen the Trust submit its provider information return and have a three day visit from our local CQC relationship lead.

The Trust provided all the required information and commentary required to meet the deadline of submission by the 18th August, 2017.

The three day visit from our local engagement lead took place between the 21st August and the 23rd August, which saw the clinical, operational and nursing leaders for each core service present to the CQC relationship lead on the first morning. The CQC relationship lead then visited each core service and held a series of staff drop in sessions.

Feedback from the CQC local relationship lead was that she was impressed by our supportive culture and it was clear from her interactions with staff that they like working for the Trust and their pride in the Trust shone through. She also thanked the Trust for the work that had gone it to provide detailed and balanced presentations on each core service. Following submission of the provider information request the CQC have approximately six weeks to undertaken their local planning meeting which will scope out their inspection visit or visits. A comprehensive inspection is expected in Quarter 3.

Having seen the presentations, we have a real opportunity to push forward and show the CQC that we never stand still, that we are always looking for ways to improve and positively that we do deliver our identified improvements for the benefit of our patients, their families and our staff.

Capital Projects Progress

Urgent Care Centre

We have been notified that the Dudley Emergency Treatment Centre is likely to be delayed up to a maximum of 5 weeks. The Trusts estates team are meeting with the contractors week commencing 27th August, 2017, to ascertain if this delay can be reduced.

The original opening date was to be the 1st November, 2017, the best case scenario for the revised timescale therefore is that we can open on the 20th November, worst case scenario the 11th December 2017. The reason for the delay is the designation of a capped mineshaft that has to be registered with the National Coal Board prior to the footings of the new build being commenced.

Guest MRI and CT Suite

The opening of the Guest MRI and CT Suite later this year remains an essential priority for both the Clinical Support Services division and Trust overall. Forming a key part of the Winter Plan in providing additional capacity at the Russells Hall site for both inpatient and ED scans, in addition to delivering increased capacity for elective throughput. Work remains ongoing at the Guest Outpatient Centre with the contractor having been on site since week commencing 31st July 2017. The original date for opening of the facility has so far been delayed by one week, with plans to open it now from 8th November 2017.

Performance Challenges

Emergency Access Standard

Despite an improving trajectory in Quarter 1, Quarter 2 has seen a deterioration in performance in both July and August. There are two main reasons and these are associated with patient flow through the main hospital bed base, and from the end of July and through into August a significant increase in ED breaches. The patient flow issues are being worked through as part of the Patient Flow Committee with a number of projects aimed at improving flow through the hospital and reducing length of stay. From mid August there has been improved bed availability but unfortunately, despite consistent efforts there has been a number of significant delays overnight in ED. I am meeting with the ED Consultant team to reinforce the importance of the 4 hour target and the Director of Operations for Medicine and Integrated care is looking at additional on-site support into the evening to further support ED performance.

Cancer Standards

The 62 day target was unfortunately failed in Quarter 1, associated with delays in both Imaging and Pathology. Quarter 2 has an improved trajectory which we are currently maintaining and are on track to deliver from September 2017.

During September we are also having an external visit from the Intensive Support Team to test our improved performance management systems and to ensure compliance against good practice.

Cancer Two Week Wait

Unfortunately during August there has been an increase in Dermatology referrals and a reduction in capacity. While additional 2 week wait slots have been provided, unfortunately the number of breaches in month meant we were unable to rectify the position in August. September performance looks to be delivered, however the Quarter may be in jeopardy due to the number of breaches in August.

A plan is being presented to the Chief Operating Officer in early September which will identify how further activity for 2 week waits can be delivered to ensure the quarterly performance standard is met.

Six Week Diagnostic Waits

An improvement trajectory has been in place since June and the monthly performance has exceeded that trajectory, we remain on track to deliver the diagnostic standard by the end of September at 99%.

Visits and Events

4th August	Allscripts Site Visit
16th August	A&E Delivery Board
18th August	MCP Collaborative Staff Briefing
21st August	Black Country Sustainability and Transformation Meeting
22nd to 24th August	CQC Engagement Visit
31st August	Trust/Summit Board to Board Meeting
4th Sept	Black Country Chief Executive/Medical Director Meeting

Fire Safety Update

Following the tragic events at Grenfell Tower Summit Healthcare instigated an independent review of the cladding on the external envelope which reports that the cladding materials are to the standard in which NHSI asked Trusts to assess against in particular the areas which accommodate in-patients.

This has confirmed that the cladding is in line with the requirements of Building Standards and the relevant sections of the HTM, requiring the surfaces of the external walls of healthcare premises to provide a surface spread of Class O.

The report highlighted a number of items that the Trust may wish to address that will ensure that out fire protection systems and processes are fully robust. These items do not pose any significant risk due the their nature and location within the estate and are further mitigated by the extensive fire detection system within all buildings

The fire risk assessment programme continues to be reviewed as part of the on-going programme. Actions arising from the independent report and the assessments will be monitored and reported through the Health, Safety and Fire Assurance Group.

Community buildings which Trust staff occupy have also been reviewed and there are four buildings which have cladding on the external envelope, all information in regards to the specification and installation details have been requested.

Local News

Reminiscence Interactive Therapy and Activities (RITA)

We have introduced new digital reminiscence therapy software to offer extra support to patients with dementia. The Reminiscence Interactive Therapy and Activities (RITA) software is a form of cognitive therapy which helps to calm, stimulate and reduce agitation in patients with dementia. The therapy has been proven to positively engage patients, who have a cognitive decline in mental abilities such as memory and thinking. The software, in the form of a tablet device, helps patients to relax, recall memories and encourage interaction between them and their families.

Nursing Times Awards Shortlist

The Trust has been shortlisted in the Nursing Times Awards 2017 in three categories: Continence Promotion and Care, Nursing in the Community and Child and Adolescent Services. Our Continence Advisors for Care Homes made the shortlist in two categories, Continence Promotion and Care and Nursing in the Community. The community based team, who work across the Dudley area, introduced two new roles to educate and support care home staff to deliver the best possible continence care to patients.

The Trust's project to improve the experience for children with learning disabilities visiting hospital also made the shortlist in the Child and Adolescent Services category.

Improvements include introducing pagers in the Children's Outpatient Department, which allows parents to leave the department if their child is anxious without the fear of missing their appointment.

Healthcare Heroes

healthcareheroes

We have launched a brand new monthly award to recognise staff who strive for excellence and exceed expectation. Healthcare Heroes will reward a team and an individual each month and the winners will be chosen by the Chief Executive and Chairman. Staff can nominate colleagues via the Trust intranet. Patients, carers and visitors can vote for their Healthcare Hero by visiting the Trust website: dudleygroup.nhs.uk

Regional Assessor Appointment

Our Head of Non-Medical Education, Bill Dainty, has been appointed Regional Assessor for Advanced Life Support (ALS) Centres in the West Midlands. ALS courses are important for medical and health professional training in the UK, and help ensure those who have a cardiac arrest receive the best care possible. As part of Bill's role as a regional assessor, he will help deliver training to more than 20,000 new ALS providers every year.

Black Country Pathology: Two New Appointments

Two appointments have been made for an initial period of three months, to take the proposed shared Black Country Pathology service to the next stage.

Operational Manager: Graham Danks is currently Services Manager for the Laboratory at The Royal Wolverhampton NHS Trust and will be seconded to this new position on a full-time basis. Graham has worked at Walsall and City Hospital and has been at Wolverhampton since 1984.

Clinical Director: Ye Lin Hock is a Consultant Histopathologist at Walsall Healthcare NHS Trust and has worked at the Trust since 1995. He will take up the Clinical Director role on a part-time, sessional basis. Ye Lin and Graham will be working with members of our BCP Oversight Group, which has representation from all four Trusts, on further detail around the proposed shared Pathology service, and will lead the development of the full business case for the four Trust Boards to review before the end of the year. They will do this working closely with members of the BCP Transitional Management Team and colleagues across all four Trusts.

Sepsis Event

We are pleased to be hosting the next Sepsis awareness event in September.
Dr Ron Daniels, founder and CEO of UK Sepsis Trust, is returning to Dudley on Friday 8th September to present ‘A survivor’s story’ alongside MP Mike Wood.

Regional NHS News

The CMA has cleared the merger between two Birmingham Hospital Trusts, after finding that it is likely to benefit patients in the local area

The Competition and Markets Authority (CMA) found that, whilst the merger between Heart of England NHS Foundation Trust (HEFT) and University Hospitals Birmingham NHS Foundation Trust (UHB) could give rise to competition concerns across a number of elective specialties, these were outweighed by the substantial improvements to patient care that were expected to arise.

Patient care in A&E corridors 'standard' at Worcestershire Acute NHS Trust

Patient privacy and dignity "remained compromised" at Worcestershire Acute Hospitals NHS Trust as a result, the Care Quality Commission (CQC) said.

In April, inspectors found "no tangible improvement in performance" since a previous assessment in November. The Trust, rated inadequate, said it had made improvements since then.

42 Hospital Trusts closed maternity wards at least once in 2016

Hospitals in England temporarily closed their maternity wards to new admissions on 382 occasions last year, compared to 375 times in 2015 and 225 occasions in 2014, with capacity issues and staff shortages among the main causes. The figures were uncovered through freedom of information requests to 136 hospital trusts with maternity units in England, where 42 (44%) out of the 96 Trusts that responded to Labour's requests said they had temporarily closed their doors on at least one occasion in 2016.

Dudley CCG rated outstanding again by NHS England

DUDLEY CCG is one of only four CCG's in the country to maintain its outstanding rating for the last two years in the annual assessment from NHS England.

It is the third year running that Dudley CCG has received the rating in the NHS England's Improvement and Assessment framework for the leadership it provides the healthcare community in Dudley and for embracing news ways of working.

New Cross Hospital building material fails fire test

A sample from the Heart and Lung Centre at New Cross Hospital in Wolverhampton failed a test, the Trust said. The Royal Wolverhampton NHS Trust said it was working with the fire service. Samples that failed tests from five other providers were from buildings that did not house patients overnight, NHS Improvement said.

All NHS Trusts and Foundation Trusts were asked to carry out urgent fire safety checks after the Grenfell Tower fire. NHS Improvement said six NHS organisations had submitted building material samples found to be aluminium composite material [ACM] and subsequently failed a combustibility test.

Unfilled NHS jobs in West Midlands hits highest number on record

The number of unfilled NHS jobs in the West Midlands has hit its joint highest figure on record. New data shows that the equivalent of 113,763 people were working full-time in the NHS in the region in March. During the same month there were 2,745 adverts for full-time jobs – meaning that one in 42 NHS jobs in the West Midlands was empty. The NHS has published monthly data on vacancies and its current staff going back to February 2015 and this figure is the joint highest on record for the West Midlands. During this time it has fluctuated between 1.8 per cent (one in 56) and 2.4 per cent (one in 42).

'Bullying still alive and well' in Walsall Manor midwifery service

Hospital chiefs were threatened with enforcement action by the health regulator over staffing levels and a 'bullying culture' within a maternity service, it has emerged.

Troubled Walsall Healthcare Trust, which runs the Manor Hospital, was given the warning in June by the Care Quality Commission, board papers reveal.

It is a further blow for the Trust which was placed in special measures in January last year for a 'heavy handed' approach, described as bordering on bullying, by senior management.

Concerns over the future of two Manor Hospital wards

A Walsall Healthcare NHS Trust said a public consultation had been launched into Stroke services based on Ward 1 at Walsall Manor Hospital. A hospital employee, who wished to remain anonymous, said staff had been told that both Ward 1 and Ward 14 – a complex discharge ward – would close later this year.

The worker said: “They have plans to close two wards, in total it is about 70 beds.

NHS staff and resource investment needed

In the West Midlands almost 7,800 posts lay vacant, up from over 7,000 in the previous year, as thinly stretched services are being pushed close to breaking point to address the shortfall. NHS staff right across the profession are struggling to manage unsustainable workloads as the inevitable toll of increasing pressure is leading to lower morale amongst staff who are dealing with higher instances of stress and burnout.

Health Trust turns down ‘demeaning’ fancy dress nurses' donation

A health Trust has turned down money for heart testing equipment because the cash was raised by male fundraisers dressed up as female nurses. The Chief Executive of the Trust in Shropshire said the bed push event, which has taken place in the market town of Ludlow for three decades, was insulting and demeaning. Over the years the bed push has raised tens of thousands of pounds, and funds raised this summer were earmarked to provide ECG equipment at Ludlow Hospital

Sandwell cancer patients could face trips to Birmingham

The Queen Elizabeth Hospital in Birmingham is planning to withdraw its Oncologists which have been allowed to work at Sandwell General Hospital at the end of September. Health chiefs in Sandwell said they were continuing to work with NHS England and commissioners to find a solution but have admitted they could lose the service, which would leave patients with tumours having to take longer journeys to see a specialist.

The Royal Wolverhampton NHS Trust launches free Wi-Fi for patients and visitors

A free Wi-Fi service is now available for patients and visitors at a number of hospital and community sites in Wolverhampton and Cannock. The wireless internet service is designed to enhance the experience of patients by enabling them to stay in touch with family and friends during their time in hospital. Those using smart phones, laptops and tablets will be able to detect the free Wi-Fi through their electronic device and connect to the internet.

National NHS News

NHS 'leaking millions' in PFI contracts

The NHS is "leaking" money to private companies in contracts to build and run hospitals, a report says. Under the Private Finance Initiative (PFI), companies provide money for new hospitals and then charge annual fees.

Homeopathy clampdown undermined by NHS doctors, campaigners warn

The battle to abolish taxpayer-funded homeopathy is being undermined by GPs and other NHS doctors who believe the alternative therapies work, campaigners have warned. The health service has announced a ban on commissioning the treatments, yet in London and the South West family doctors continue to prescribe them, and some NHS hospitals deliver them, costing up to £6 million a year.

NHS patients waiting for hospital care top 4m for first time in a decade

More than 4 million patients are waiting to be admitted to hospital in England to have surgery, the highest number in 10 years, the latest official NHS performance statistics reveal. Hospital bosses said the figure, and a series of missed performance targets on A&E and cancer care, showed that the health service was now unsustainable. Shortages of money, staff and care outside hospitals to keep patients well meant that it could not cope with an ongoing and unprecedented rise in demand, they said.

Nursing crisis is leaving NHS hospitals unsafe as some of the country's biggest Trusts do not have staff they need

Nine in ten of England's largest hospital Trusts are struggling to hire enough nurses to keep patients safe, damning new stats show. Almost all the 50 largest Trusts - which together run 150 hospitals - are missing their own safe staffing targets according to the Royal College of Nursing (RCN).

It's all systems go for the new Health and Social Care Network

NHS Digital's new NHS Network, Health and Social Care Network is in full force with the transition from the old N3 network now underway. The contract for the legacy NHS National Network (N3) infrastructure, supplied by BT, expired in March this year, with health and care organisations set to start to deploy connections to the replacement HSCN from October.

NHS accused of shrouding £500m of planned cuts in secrecy

Doctors' leaders have accused NHS bosses of shrouding controversial plans for £500m of cuts to services across England in "totally unacceptable secrecy".

Patients deserve to know how hospitals being told to "think the unthinkable" as part of the savings drive will affect their access to healthcare, the British Medical Association (BMA) said on Friday.

NHS staff: How many foreign staff work in the NHS?

UCAS announced earlier this year that there had been a notable decrease in students from England applying to do at least one nursing course, saying it had fallen 23% to 33,810 in 2017. Chancellor Philip Hammond spoke last week about the "very high numbers of foreign workers keeping our NHS going".

18 'serious' personal data loss incidents probed by health officials

Health officials in England investigated 18 "serious incidents" relating to loss or disclosure of personal sensitive data last year. These incidents included a bag of medical records being left outside a medical practice and an investigation into hospital patient record data shared with a "third party". Twelve of the 18 incidents were related to the Primary Care Support England service which is run by the private firm Capita - in September 2015, NHS England commissioned Capita to run the service, which handles GP payments, medical supplies, moving records and patient registrations.

'Very weak' passwords put NHS hospitals at hacking risk

NHS hospitals are at risk of further devastating cyber attacks because staff are using “very weak” passwords, a new report reveals. Health chiefs warned that one in four official user accounts granting access to sensitive patient data and vital systems are inadequately protected, while many organisations are failing to update their security software.

NHS Hack Attack

Anonymous hacker claims to have stolen private data on up to 1.2million NHS patients. A computer geek with alleged links to global hacking group Anonymous has stolen patient data from an NHS appointment booking system.

The crook breached a private contractor’s security to access a database containing confidential records on up to 1.2million people.

NHS patients express increasing dissatisfaction with levels of privacy

NHS patients are increasingly dissatisfied with the level of privacy afforded to them in hospital, a new report has revealed, after repeated Government failures to close mixed-sex wards. A patient-led study assessing the non-clinical aspect of NHS care shows that scores in the area of "privacy, dignity and wellbeing" have decreased by four per cent since 2014.

NHS Digital endorses “Every nurse an e-nurse” campaign

NHS Digital has endorsed a national campaign to encourage digital training for nurses at the launch of its inaugural e-nursing week. The Royal College of Nursing’s (RCN) “Every nurse an e-nurse” wants every UK nurse to be an e-nurse by 2020.

Operating on the wrong person and patients falling out of windows – NHS 'never events' at near record levels

Patients falling out of windows and equipment being left inside wounds after surgery were some of a near record number of 'never events' recorded by the NHS last year.

Campaigners have warned the same life-threatening mistakes, for which there can never be an excuse, are "disturbingly high" and often repeated, as official data reveals wrong site surgery took place 178 times in the 12 months before April.

NHS: Year-long surgery waiting lists up 400% in Wales over four years

Numbers of patients in Wales waiting more than a year for surgery have gone up by 400% in just four years. The Royal College of Surgeons asked every health board in Wales how many people had been on the waiting list for longer than 52 weeks.

Its Freedom of Information requests revealed that in March 2017 there were 3,605 patients waiting over a year, compared to 699 in March 2013.

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 7 September 2017

TITLE:	**29 August 2017 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe – Director of Governance	**PRESENTER**	Doug Wulff – Committee Chair

CORPORATE OBJECTIVES
SO 1 – Deliver a great patient experience
SO 2 – Safe and caring services

SUMMARY OF KEY ISSUES:
The attached provides a summary of the assurances received at this meeting, the decisions taken, the tracking of actions for subsequent meetings of this Committee and the action the Committee is seeking the Board to take.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description: N/A**
	Risk Register: N		**Risk Score: N/A**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

The Committee requests the Board to note the assurances received at the meeting and the decisions made by the Committee, specifically:- .

- In respect of referring to the Quality and Safety Group the requirement to secure assurance over compliance with the Open Systems Alert.
- The endorsement of the work of the clinical audit team to project manage the Divisional review of NICE guidance
- The scheduled deep dives across the next five months of three risks. One a new risk (learning from deaths), one an escalated risk (ophthalmology capacity) and one a more longstanding risk (the accessible information standard).

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	29 August 2017	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- An update was provided in respect of the Maternity Service Improvement Plan. The report provided assurance in respect of progress and the executive oversight of the action tracking process which takes place within the Division and the Directorate. Given the proximity to the QIB report to Board the Committee asked that a further paper be brought to the next Committee meeting.
- The outcome of the continued weekly audits on compliance with the National Patient Safety Agency Alert in respect of Naso Gastric Tube placements was received by the Committee. The report provided feedback on community activity as requested at the last Committee meeting. There continues to be improvement in the latest results and the audits of compliance will now form part of the routine Nursing Care Indicator audit programme from October.
- An update was provided on a number of grade 4 Pressure Ulcers that have occurred within the Trust. The Committee were informed of increased oversight being provided via a Stage 4 Chief Nurse Pressure Ulcer Review Panel. This Panel will follow through on the application of the learning from the RCAs. The report was asked for last month and a further update will be brought to the Committee next month.
- Executive Management assurance was provided on the quality aspects of Trust performance in respect of key quality indicators. The Committee noted that there had been improvement within the Friends and Family response rates and recommended scores for all areas except for the Emergency Department. The Committee considered the added narrative as requested at the last meeting for areas where a lower Friends and Family recommended score was achieved. The Committee was informed that with the building works going on within ED may have impacted on both the recommended scores and the footfall (response rates). The Committee asked that in respect of VTE performance the Quality and Safety Group secure assurance that for each case where an assessment was not done that there were no quality of care issues. The Committee noted that if there were serious issues these would have resulted in an SI.
- The Support Services division provided an update on the action taken and provided assurance to the Committee that the previous actions in respect of plain

film review continued to mean that there was no backlog in reporting. The Medicine Division provided an update on performance challenges and highlighted that a significant contributory factor to these issues lay in workforce recruitment. This risk is on the divisional risk register and that performance information on recruitment and retention is taken to the Workforce Committee. The Surgery Division confirmed they also had the appropriate risks within their risk register relating to performance challenges highlighted within the performance report.

- The newly developed maternity dashboard was presented to the Committee. The dashboard covered a mix of quality and operational performance, governance and workforce measures. The Committee welcomed this specific dashboard and is looking forward to the integrated dashboard having all performance reporting in one report.
- The Clinical Chief Information Officer provided an update on the Digital Trust project including details of the individual digital projects underway. The Clinical Chief Information Officer following a request of the Committee for executive support for the delivery of "Point of Care testing" advised of the progress now being made in respect of this project. The Committee was updated on actions being taken in respect of the NORSE system used by the Trust and UHB. The Committee endorsed that whilst the issue is being discussed with the relevant operational medical leads at UHB a risk should be recorded on the Trust's Medical Division's risk register.
- Executive Management assurance was provided in respect of the Trust's processes for receiving, disseminating and assessing NICE guidance. The Committee was informed of the enhanced role the Clinical Audit team are taking over the next three months to work with the Divisions and the specialty leads to improve the Trust's assessment processes and thus mitigate the local divisional risks in relation to compliance with NICE guidance. A further report showing the improvement to the Trust's processes will be brought back to the Committee next month.
- The Committee received the update in respect of Medicines Management as the agreed Medicines Management Group has yet to meet. The report provided assurance on Medicines Management audits being undertaken, the use of "p notes" to Datix medicine prescribing advice and guidance to reduce the potential for future error. The Committee requested the Associate Chief Nurse for Medicine to review the current discharge Standard Operating Procedure to ensure it is clear about verifying the return of patients' own medicine prior to discharge.
- The Associate Director of Medicines Optimisation and Head of Pharmacy presented a paper in respect of the risks in relation to a national shortage of a specific drug. The paper presented the options developed to enable a move to an alternate drug should the supply chain of the current drug not be able to deliver to the level the Trust needs.
- The Committee received a report on the qualitative aspects of the estates contract management processes in respect of both estates and facilities. The Committee received a further update on a Never Event and the actions undertaken by the Trust as a result. The report also identified that work was progressing within the area of the Trust asset register especially within Community. A discussion was held about extra cooling equipment available in exceptional circumstances and

that the Trust has sourced more directly held equipment to reduce the lag in this being available for the Trust.

- The Committee received a report from the Health, Safety and Fire Assurance Group. The report updated the Committee on the Trust support to staff in respect of hand wash and moisturising. The work planned within the C Wards to improve compartmentalisation following a number of ward reconfigurations was noted.
- The Committee received a report from the Quality and Safety Group and noted the focus on the work of the Hospital Transfusion Group, the work being undertaken in respect of Medicines Management, in particular with regards to oxygen prescribing, and the results of the latest ward round checklist audit.
- The Committee received a report in respect of the activity of the Internal Safeguarding Board. The Committee was updated as to the actions being taken in respect of the issue of compliance with safeguarding training.
- The Committee received a report in respect of the tracking of external reviews undertaken across the Trust. The reported provided assurance that where reviews had highlighted issues these were being placed on the relevant risk register thus supporting the tracking of actions taken. The Committee considered the reviews where actions were reported as completed and were assured these could be closed.
- The serious incident report documented the Trust's continued focus on learning and improvement, supported by a separate quarterly report on learning which is shared with the CCG as part of our contractual requirement and internally with our staff to promote learning. The report provided assurance that the Trust has complied with the reporting requirement timescales in respect of initially reporting of Serious Incidents (SIs) within two days. However, on conducting and closing 12 Pressure Ulcer SIs the two day reporting date was found to have been failed. The Trust failed to close 6 investigations within the 60 day timescale this month, all related to either more information being required by the lead investigator or the lead director before the RCA could be submitted to the CCG. The Committee was informed that further RCA training has been commissioned and is being provided to staff to improve the incident investigation and reporting being undertaken. The number of actions not being implemented in line with the agreed RCA action plans timescales has reduced this month to 3 (from the 5 last month). The Serious Incident report also provided assurance regarding the Trust's engagement with families when a serious incident occurs through the auditing of the Trust's compliance with the duty of candour.
- Executive Management assurance was provided in respect of the Trust's processes for receiving, disseminating and assessing NPSA alters. The Committee was assured that he central processes had also been subject to an Internal Audit review reported to the Audit Committee giving substantial assurance over those processes. The Committee was updated on a change in the process that now requires all significant safety alerts to be subject to a routine audit to determine compliance with the Alert in the same way the NG Tube alert has been subject to regular audit. The Committee endorsed this process enhancement and agreed to refer the recent Open Systems alert to the Medicines Management Group to seek audit assurance of the Trust's compliance with this specific alert.

- The Committee was updated on the progress made in reviewing policies and guidelines timely. The Committee reiterated previous comments that the Divisions need to undertake the timely review of all SoPs and Guidelines.

Decisions Made/Items Approved

- The Committee requested the Quality and Safety Group to secure assurance that where VTE assessments were not undertaken this did not result in significant care issues.
- The Committee requested that whilst discussions are being held with UHB regarding NORSE a risk assessment is undertaken and a risk placed on the Divisional Risk Register to aid the tracking of the closure of the required actions by all parties.
- The Committee requested that the Associate Chief Nurse for Medicine review the current discharge SoP to make ensure it is clear about verifying the return of patients' own medicine prior to discharge.
- The Committee endorsed the closure of the external reviews where actions were reported as completed.
- The Committee supported the closure of 49 Root Cause Analyses (RCA) action plans following assurance from the Corporate Governance Team that, where appropriate, completed actions plans had been evidenced.
- The Committee agreed to refer the recent Open Systems alert to the Medicines Management Group for oversight of audit assurance of compliance with this specific alert.
- The Committee approved 4 policies, three of which were new policies.
- The Committee agreed to undertake a deep dive on three risks, one a new risk (learning from deaths), one an escalated risk (ophthalmology capacity) and one a more longstanding risk (the accessible information standard).

Actions to come back to Committee (items the Committee is keeping an eye on)

- A further report on the Maternity Services Improvement Plan be brought to the next meeting.
- A further report on the learning from the RCAs undertaken in respect of the grade 4 pressure ulcer be brought to the next meeting.
- Further details on the outcome of the audit of caesarian section activity due to conclude in September and report in October.
- A further report showing the improvement in the Trust NICE guidance assessment processes to be brought back to the next Committee meeting.

Items referred to the Board for decision or action
The Committee requests the Board to note the assurances received at the meeting and the decisions made by the Committee, specifically :- . - In respect of referring to the Quality and Safety Group the requirement to secure assurance on compliance with the Open Systems Alert. - The endorsement of the work of the clinical audit team to project manage the Divisional review of NICE guidance. - The scheduled deep dives across the next five months of three risks. One a new risk (learning from deaths), one an escalated risk (ophthalmology capacity) and one a more longstanding risk (the accessible information standard).

Enclosure 5

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 7 September 2017

TITLE:	**22 August 2017 Audit Committee Summary Report to the Board**		
AUTHOR:	Richard Miner – Committee Chair	**PRESENTER**	Richard Miner – Committee Chair

CORPORATE OBJECTIVES

ALL

SUMMARY OF KEY ISSUES:

The attached provides a summary of the assurances received at this meeting, the decisions taken, the tracking of actions for subsequent meetings of this Committee and the action the Committee is seeking the Board to take.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description: N/A**
	Risk Register: N		**Risk Score: N/A**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

To note the assurances received via the Committee, the decisions taken in accordance with the Committee's terms of reference and action any items referred to the Board.

Audit Committee highlights report to Board

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**22/8/2017**	**Richard Miner**	**yes**	**no**
			x	

Declarations of Interest Made

None

Assurances Received

- That R&D research studies continue albeit that attaining recruitment levels is still a challenge.
- That progress is being made against the 2017/18 Internal Audit plan. This included receiving a "Reasonable Assurance" report in respect of the follow up of high and medium priority management actions (phase 1) and a "Substantial Assurance" in respect of National Patient Safety (NPSA) Alerts – Central Processes. Further "advisory reports" were received in respect of Appraisals (Benchmarking) and Mandatory Training.
- That counter-fraud (mainly pro-active fraud awareness sessions) initiatives continue with a view to prevention.
- The continuing work of the Caldicott and Information Governance Group, including the approval of 3 policies (with no actions required at this stage from the Audit Committee).
- That the assurances received from the Risk and Assurance Group that met on 19 July, supporting the risk assessments made by the Executive Team.
- The declining and relatively low level of losses and special payments made up to 30 June 2017.

Decisions Made / Items Approved

The Committee:

- Ratified the Trust's revised Standards of Business Conduct Policy, which incorporates the NHS England revised guidance requirements.
- Approved 7 changes to the Internal Audit Plan.
- Noted the loss report for Quarter 1 and for 2017/18.
- Reviewed and approved an additional 6 clinical audits (4 of which are due to national guidelines) to the 2017/18 Annual Clinical Audit Plan.

Actions to come back to Committee / Group (Items Committee / Group keeping an eye on)

- A further "deep dive" into workforce issues, particularly concerning appraisals and mandatory training, as identified in the Internal Audit progress report. This will include Rachel Andrew reporting to the Committee.
- The outcome of data quality follow-up work due to a previous "red" opinion (VTE data quality).
- Monitoring of management actions and timescales identified – 40 recommended Internal Audit actions are still outstanding.

Audit Committee highlights report to Board

Items referred to the Board / Parent Committee for decision or action

- To recommend the Risk Register and Assurance Register, together forming the Board Assurance Framework be approved.
- To ask the workforce committee to consider how the effectiveness of the appraisal system and mandatory training can be improved so as to fulfil Strategic Objective 4 – be the place people choose to work.

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors August 2017 - PUBLIC

TITLE:	Chief Nurse Report - Infection Prevention and Control Forum		
AUTHOR:	Dr E Rees, Director of Infection Prevention and Control	**PRESENTER:**	Siobhan Jordan Interim Chief Nurse

CORPORATE OBJECTIVE:

SO1 – Deliver a great patient experience

SO2 – Safe and caring services

SO3 – Drive service improvements, innovation and transformation

SO4 – Be the place people chose to work

SO6 – Plan for a viable future

SUMMARY OF KEY ISSUES:

For the month of July (as at 25.7.17)

- No post 48 hr MRSA bacteraemia cases since 27th September 2015
- No Norovirus episodes.
- There have been 5 MSSA bacteraemias identified in the Trust of which none are post 48 hr cases.
- There have been 12 E. coli bacteraemias identified in the Trust of which 3 are post 48 hr cases.
- As of this date the Trust has had 10 cases of post 48 hr C. difficile so far in 2017/18 and 1 case for August 2017.
- To receive & approve the Annual Infection Prevention & Control Report 2016/17

IMPLICATIONS OF PAPER:

RISK	**Yes**		**Risk Description:** Failing to meet minimum standards
	Risk Register: Yes		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details:** Safe and effective care
	Monitor	**Yes**	**Details:** MRSA and C. difficile targets
	Other	**Yes**	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF BOARD

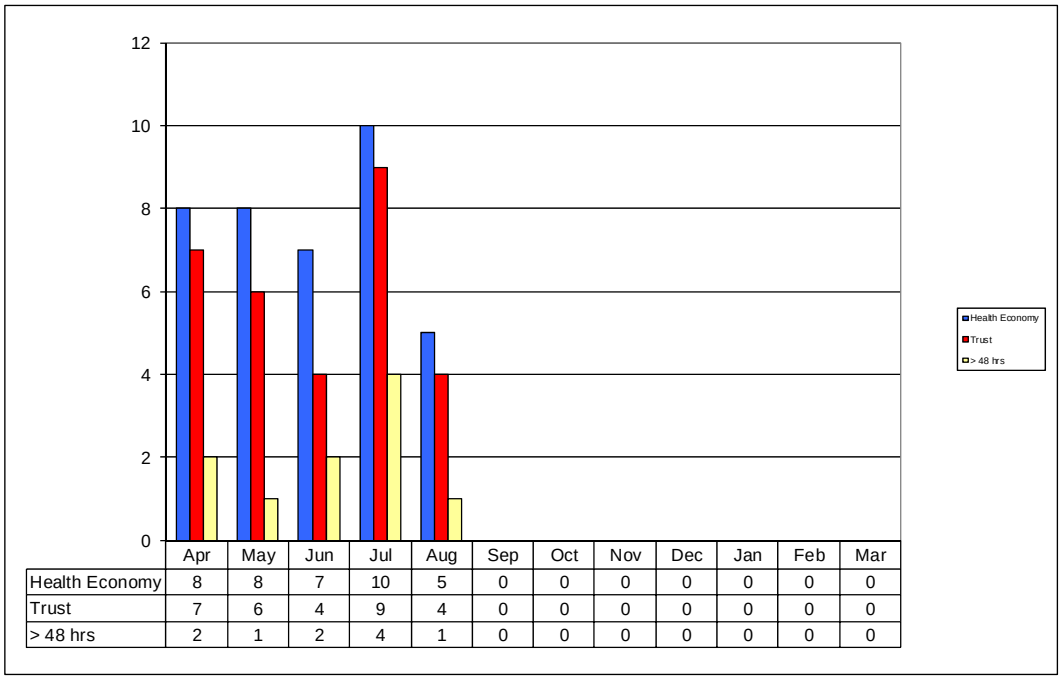
Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE BOARD:
To receive the report and note the contents.

Summary:

<u>Clostridium Difficile</u> – The target for 2017/18 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. Penalties will be associated with exceeding 29 cases associated with lapses in care. At the time of writing (31.817) we have had 1 post 48 hour case recorded in August 2017.

C. DIFFICILE CASES 2017/18



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	8	7	10	5	0	0	0	0	0	0	0
Trust	7	6	4	9	4	0	0	0	0	0	0	0
> 48 hrs	2	1	2	4	1	0	0	0	0	0	0	0

The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], continues.

For the financial period 2017/18 there has so far been 10 post 48 hour case identified since 1st April 2017. There is 1 case for August 2017 to date. Of these 10 cases 8 are lapses in care and the remaining 2 are under review. Of the 8 apportioned cases the lapses in care associated are: failure by areas to meet their mandatory IC training targets, cleaning score below the required standard and failure to complete a stool chart on admission of the patient.

There is a Trustwide C. difficile action plan in place to address issues identified by the RCA process as well as local plans for each individual case. Progress against the plan is recorded at the Infection Prevention Forum.

<u>MRSA bacteraemia (Post 48 hrs)</u> – There have been 0 post 48 hour MRSA bacteraemia cases since 27th September 2015.

<u>MSSA bacteraemia (Post 48 hrs)</u> – no post 48 hr cases for August to date.

MRSA screening – The Trust screens emergency admissions as well as appropriate elective surgical cases. The percentage of emergency admissions for July is 91.7% (last complete set of data available).

The percentage of elective admissions for July is 90.6%. There has been a lot of work to accurately record the data for elective screening. This has resulted in confidence that the surgical elective MRSA screening compliance is approaching 100%, the medical elective surgery dataset requires further work which should be completed to provide robust data for the next report.

E. coli bacteraemia – For the post 48 hr cases an enhanced surveillance module has been commenced in April 2017 in order to ascertain themes and trends within the acute Trust to see where lessons may be learnt. There are 3 post 48 hr cases for August to date and enhanced surveillance is being undertaken on those cases.

Infection Control Mandatory Training – Percentage compliance as at 30.6.17 (target 90%)

Area	Clinical	Non Clinical
Corporate/Management	83%	91%
Medicine and Integrated Care	90%	95%
Surgery	89%	95%

There is work on going to address the Infection Control Mandatory training to ensure ward areas meet their target within a short time frame. Currently there are 2 face to face sessions available per month for ward staff, e learning is available at all times and the Infection Control Team proactively approaches wards to arrange local training. During August 5 additional sessions were provided delivering training to 40 members of staff.

Environment and Hand Hygiene – ICT will be working with the Trust's PFI partner to scope the impact of the revised Cleaning Policy. The Trust has also awarded the contract to one provider to deliver the hand decontamination and hand care products required in the Trust. In the last week the company have visited the site to scope the clinical areas to ensure that the implementation planned for the end of September can be delivered.

Infection Prevention and Control Forum – The last meeting of the Forum was held on 15th August 2017. There was a discussion about the Terms of Reference (ToR) for the Forum. It was agreed to increase the frequency of the meetings to 10 per annum from the current alternate month arrangements and to introduce a cycle of reporting to ensure adequate time for discussion of agenda items. The membership was also reviewed and approved to reflect the revised divisional structures. The mandatory reports and MRSA screening were discussed (see above for details). Environmental issues were discussed particularly the plan to review areas in the Trust with carpet to ensure that any change of use has been addressed. The cleaning policy was discussed and the Trust is awaiting further responses from the PFI partners before progressing the work further.

Infection Prevention and Control Report 2016/17

The Board is asked to receive and approve the attached report.

Reference

1. *Clostridium difficile* infection objectives for NHS organisations in 2016/17 and guidance on sanction implementation, Public Health England.

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 7th September 2017

TITLE:	Monthly Nurse/Midwife Staffing Position – September 2017 report containing July 2017 data		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER:**	Siobhan Jordan Interim Chief Nurse

CORPORATE OBJECTIVE:
SO1: Deliver a great patient experience SO2: Safe and Caring Services

SUMMARY OF KEY ISSUES:

The attached paper contains the actual and planned hours for qualified and unqualified staff for both day and night shifts for each area of the hospital. The fill rates and the Care Hours per Patient Day (CHPPD) are also tabled. It can be seen that in general the fill rates are generally close to but less that one hundred percent of the current establishment and there has been some improvement in these figures from early in the year (January/February).

With regards to the staffing review:

- Phase 1 covering the Surgical Wards is now complete. The proposed increase in staffing was discussed at the Finance and Performance Committee in July.
- Phase 2 covering Paediatrics and the Neonatal Unit is complete.
- Phase 2a covering the Critical Care Unit is complete.
- Phase 3 covering the Medical Wards is part completed with all wards/areas now having their initial meetings.
- Phase 4 will consist of the other areas within the hospital.
- Phase 5 the Community.

Following the completion of Phase 1 the Chief Nurse and the Human Resources Director have drawn up an implementation plan to ensure effective recruitment and retention in order to have a substantive workforce providing high quality patient care.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:**
	Risk Register		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	N	**Details**:
	Monitor	Y	**Details:**
	Other	Y	**Details**: Internal Audit

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: To note and consider the safe staffing data and the position with the ongoing staffing review.

Monthly Nurse/Midwife Staffing Position

September 2017 Report containing July 2017 data

The attached Safer Staffing Summary (Appendix1) shows the actual and planned hours for four categories of staff, qualified and unqualified staff for both day and night shifts, for each area of the Trust for July 2017 (wards that have been fully or partially closed in the month are omitted). As well as showing the actual and planned hours the report shows the fill rate for each of the four categories. The totals for the Trust are also indicated. In addition, the last four columns show the actual Care Hours Per Patient Day (CHPPD). We provide this information to NHS Improvement and part of it is utilised in the National Model Hospital dataset.

The report shows that the overall fill rates for the Trust are nearly 100% but this has been achieved by using the present establishments and a significant reliance on temporary staff (bank and agency). A number of factors make it unlikely that a full fill rate will always be achieved although this is the aim. These factors include long term issues such as vacancies, short term issues such as sickness and maternity leave, the unavailability of temporary staff and unexpected numbers of patients requiring enhanced care.

It can be seen that for individual wards the fill rates vary although in the main they are close to 100%. On occasion, the fill rate is over 100%. C2, the paediatric ward, is a particular exception with regards to this as the planned hours are derived from the RCN dependency tool. Each shift the planned hours are determined by the acuity of the children on the ward. Sometimes there are occasions when the fill rate of unqualified staff goes above 100%. This occurs when it is recognised that there will be a reduction in qualified staff (e.g. C5 at night).

The chart below shows that the percentage fill rates have been improving over the year.

Table 1. Percentage fill rates January 2017 to the present

	Qualified Day	**Unqualified Day**	**Qualified Night**	**Unqualified Night**
Jan	94%	96%	94%	99%
Feb	93%	95%	96%	99%
Mar	95%	97%	97%	100%
Apr	97%	96%	98%	98%
May	97%	97%	99%	98%
June	96%	96%	98%	99%
July	96%	97%	98%	100%

With regards to the CHPPD, as has been explained in previous monthly reports this is a new indicator that can be used to benchmark the Trust.

Table 2. Care Hours Per Patient Day (CHPPD) – Overall Trust Regional Comparators

2017 Month	TRUST Nurse & Midwife	Midlands & East Median	National Median	TRUST Care Support Workers	Midlands & East Median	National Median	TRUST Total number	Midlands & East Median	National Median
January	4.30	4.7	4.7	3.50	2.9	2.9	7.8	7.7	7.6
February	4.34	N/A	N/A	3.63	N/A	N/A	7.97	N/A	N/A
March	4.44	N/A	N/A	3.74	N/A	N/A	8.18	N/A	N/A
April	4.55	4.8	4.8	3.73	3.1	3.1	8.28	7.8	7.9
May	4.4	4.9	4.8	3.8	3.1	3.1	8.2	7.9	7.9
June	4.36	N/A	N/A	3.58	N/A	N/A	7.95	N/A	N/A
July	4.23	N/A	N/A	3.65	N/A	N/A	7.88	N/A	N/A

N/A = Data not yet available

The latest published regional and national average figures for May indicate that the Trust is below these averages for qualified staff but higher for care support workers.

As part of the staffing review being undertaken the comparative data in the Model Hospital has been considered. The examples for surgery that were in this paper last month provided useful comparative information when formulating proposed staffing levels for those areas. The next stage of the staffing review has looked at some of the specialist areas and the usefulness of the comparative data is less obvious. In Table 3 below the data for these specialised areas is outlined.

Table 3. Care Hours Per Patient Day (CHPPD) for Specialist Areas – Trust and Regional and National Medians

Speciality/ Staffing Type				
Paediatrics	**C2**	**NNU**	**Peer Median**	**National Median**
Total	***7.34***	***10.75***	11.69	12.45
Registered	***5.95***	10.75	8.91	4.89
HCSW	***1.39***	***0***	2.35	2.24
Critical Care	**ITU/SHDU**		**Peer Median**	**National Median**
Total	***25.18***		27.27	25.99
Registered	***23.21***		25.08	23.84
HCSW	***1.97***		2.3	2.37

(Peer Median is for NHSI Region) (These figures from May 2017 are the latest available)

The paediatric figures need to be interpreted with caution as the Model Hospital has only a single median figure for both paediatrics and neonates and one would expect these to be different based on the different nature of a specialist unit compared to a general paediatric ward.

All Trust figures that are less than both the peer and national median have been put into bold and italics and it can be seen that for all three areas all of total staffing are less than both medians. This also applies to unregistered staff in all three areas and registered staff in both

paediatrics and critical care. The higher than the median registered staff in NNU can be explained by there just being one median for both NNU and general paediatrics. The review findings have confirmed staff to patient ratios less than national standards.

The Trust is just starting to use this comparative data and this will continue and become more refined as time progresses. A visit from NHSI specialists on both nurse staffing and this data is being arranged.

Conclusion

This report demonstrates that we are achieving nearly 100% fill rate and there is a continued commitment to do so. Benchmarking the Trust workforce data using the CHPPD can be informative and will continue.

The staffing review which commenced in May is using data from a wide variety of sources to inform and ensure the required outcome. As well as considering the above data, the review is structured discussions with senior nurses from each area together with their managers using information on establishments, staffing ratios and vacancy, sickness and temporary staffing rates. It is also considering the outcome of the most recent six monthly Safer Nursing Tool exercise. The outcome of the five phases of the review (1 Surgery, 2 Neonates and Paediatrics, 2a Critical Care, 3 Medicine, 4 Rest of the Hospital and 5 Community) will be reported, as agreed, to the Board of Directors as each phase is completed. The first phase outcome has been agreed at the Finance and Performance Committee in July and at the Board of Directors in August. The second phase has been completed and is awaiting agreement.

APPENDIX 1

Safer Staffing Summary **Jul** Days in Month 31

Ward	Day RN Day RM Plan	Day RN Day RM Actual	Day CSW Day MSW Plan	Day CSW Day MSW Actual	Night RN Night RM Plan	Night RN Night RM Actual	Night CSW Night MSW Plan	Night CSW Night MSW Actual	Qual Day	UnQual Day	Qual N	UnQual N	Actual CHPPD Sum 24:00 Occ	Actual CHPPD Registered	Actual CHPPD Care staff	Actual CHPPD Total
Evergreen																
A2	248	241	220	212	156	154	191	191	97%	96%	99%	100%	1,130	4.09	4.28	8.37
A3																
A4																
B1	117	112	66	64	69	69	65	62	96%	97%	100%	95%	591	3.58	2.55	6.13
B2(H)	124	118	248	223	93	92	216	212	95%	90%	99%	98%	891	2.83	5.86	8.69
B2(T)	93	89	169	162	62	62	138	140	96%	96%	100%	101%	694	2.55	5.21	7.76
B3	191	182	203	188	157	149	178	170	95%	93%	95%	96%	999	3.88	4.21	8.09
B4	186	178	219	197	155	152	157	149	96%	90%	98%	95%	1,364	2.90	3.04	5.95
B5	186	174	123	120	158	153	93	93	94%	98%	97%	100%	1,008	3.81	2.54	6.34
B6																
C1	186	176	323	296	155	145	203	194	95%	92%	94%	96%	1,418	2.65	4.15	6.80
C2	194	220	93	81	166	170	62	62	114%	87%	103%	100%	710	6.44	2.19	8.63
C3	189	184	393	387	157	154	385	383	97%	98%	98%	99%	1,587	2.56	5.82	8.37
C4	155	139	72	72	93	92	93	93	90%	100%	99%	100%	665	3.96	2.98	6.94
C5	186	167	242	285	155	137	177	225	90%	118%	88%	127%	1,393	2.50	4.39	6.89
C6	93	94	89	75	62	62	89	82	101%	84%	100%	92%	506	3.61	3.72	7.33
C7	186	178	136	138	124	121	135	135	96%	101%	98%	100%	1,109	3.16	2.95	6.11
C8	203	191	217	226	186	180	217	217	94%	104%	97%	100%	2,510	1.70	2.12	3.82
CCU_PCCU	217	177	56	57	155	153	25	26	81%	101%	99%	104%	671	5.89	1.48	7.37
Critical Care	295	295	60	60	293	293	-	-	100%	100%	100%		284	24.31	2.22	26.52
EAU	186	179	155	145	155	155	155	150	96%	94%	100%	97%	710	5.52	4.99	10.51
Maternity	548	529	217	206	527	518	155	152	97%	95%	98%	98%	576	17.68	7.28	24.96
MHDU	122	111	38	35	121	111	6	5	91%	92%	92%	83%	222	11.75	2.09	13.84
NNU	192	187	6	6	191	184	-	-	97%	105%	96%		493	8.83	0.12	8.95
TOTAL	**4,096**	**3,919**	**3,344**	**3,233**	**3,390**	**3,306**	**2,740**	**2,741**	**96%**	**97%**	**98%**	**100%**	**19,531**	**4.23**	**3.65**	**7.88**

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 7th September 2017

TITLE:	Infection Control Annual Report 2016 - 2017		
AUTHOR:	Dr E Rees Director of Infection Prevention and Control	**PRESENTER:**	Dr E Rees Director of Infection Prevention and Control

CORPORATE OBJECTIVE:
SO1 – Deliver a great patient experience
SO2 – Safe and caring services
SO3 – Drive service improvements, innovation and transformation
SO4 – Be the place people chose to work
SO6 – Plan for a viable future

SUMMARY

The Dudley Group NHS Foundation Trust is committed to ensuring that a robust infection prevention and control function operates within all clinical areas of the organisation which supports the delivery of high quality healthcare and protects the health of its service users and staff.

The Annual report seeks to provide assurance to the organisation with regards to the progress of the prevention, control and management of infection from April 2016 to March 2017.

IMPLICATIONS OF PAPER:

RISK	**Yes**		**Risk Description:** Failing to meet minimum standards
	Risk Register: Yes		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details:** Safe and effective care
	Monitor	**Yes**	**Details:**
	Other	**Yes**	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE BOARD:
To receive the report and note the contents.

The Dudley Group
NHS Foundation Trust

INFECTION PREVENTION AND CONTROL REPORT

2016/17

CONTENTS

LIST OF ABBREVIATIONS

C.diff	Clostridium difficile
CQC	The Care Quality Commission – the integrated regulator of health and adult social care
DH	Department of Health
D and/or **V**	Diarrhoea and/or Vomiting
DIPC	Director of Infection Prevention and Control. An individual with overall responsibility for infection control and accountable to the registered provider
E-Coli	Escherichia coli
ESBL	Extended-Spectrum Beta-Lactamases (ESBLs) are enzymes that can be produced by bacteria making them resistant to cephalosporins e.g. cefuroxime, cefotaxime and ceftazidime - which are the most widely used antibiotics in many hospitals
GQC	Governance and Quality Committee
GRE	Glycopeptide-Resistant Enterococci
HCAI	Health Care Associated Infections
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
IPCLN	Infection Prevention and Control Lead Nurse
IPCT	Infection Prevention and Control Team
MRSA	Meticillin-resistant Staphylococcus aureus
MSSA	Meticillin-sensitive Staphylococcus aureus
OHD	Occupational Health Department
PLACE	Patient Led Assessment of the Care Environment
PPE	Personal Protective Equipment
SLA	Service Level Agreement
UTI	Urinary Tract Infection

1.0 EXECUTIVE SUMMARY

The Dudley Group NHS Foundation Trust is committed to ensuring that a robust infection prevention and control function operates within all clinical areas of the organisation which supports the delivery of high quality healthcare and protects the health of its service users and staff.

The Annual report seeks to provide assurance to the organisation with regards to the progress of the prevention, control and management of infection from April 2016 to March 2017.

2.0 INTRODUCTION

The Dudley Group NHS Foundation Trust recognises that the effective prevention and control of Healthcare Associated Infections (HCAIs) is essential to patient and staff safety and to the overall performance of the organisation.

The strategic approach to HCAI prevention and control is fundamental to the delivery of the Trust's organisational objectives in relation to patient safety, clinical governance and performance and is in accordance with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (revised 2015).

Effective infection prevention and control (IPC) systems and the development of a committed approach to learning will ensure that the Dudley Group NHS Foundation Trust continues to develop and improve the safety and quality of patient care.

Table 1

Health and Social Care Act 2008 - Code of Practice for health and adult social care on the prevention and control of infections.

The table below is the 'Code of Practice' for all providers of healthcare and adult social care on the prevention of infections under The Health and Social Care Act 2008. This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to infection prevention. Not all criteria will apply to every regulated activity.

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may post to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have adhere to policies, designed for the individuals care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

3.0 INFECTION PREVENTION AND CONTROL ARRANGEMENTS

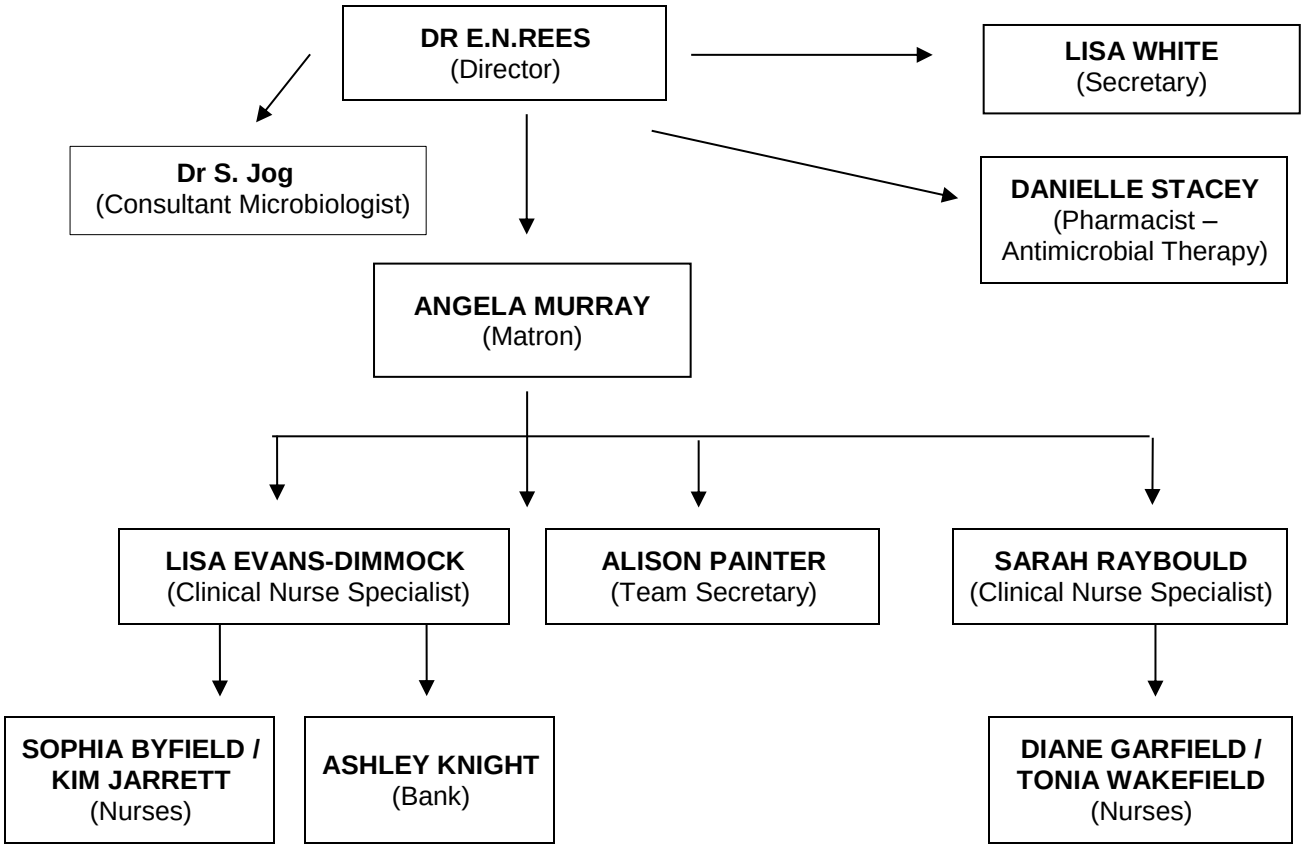
Within the Trust the DIPC role is within the portfolio of the Consultant Microbiologist / Infection Control Doctor. A key responsibility of the DIPC is to produce an annual report. Additional support is provided by the antimicrobial pharmacists, Consultant Microbiologist and Matron for Infection Prevention and Control.

The specialist infection, prevention and control nursing team provide education, support and advice to all Trust staff with regard to infection control matters and liaise regularly with patients and relatives to provide information on alert organisms, offering advice and reassurance when required.

INFECTION PREVENTION & CONTROL TEAM

Consultant Microbiologists / Infection Control Doctors

- Dr E.N. Rees
- Dr S. Jog



4.0 THE INFECTION PREVENTION AND CONTROL FORUM

The Infection Prevention and Control Forum meet quarterly and is chaired by the DIPC.

The purpose of the forum is to oversee compliance of the Health Act 2008 Code of Practice for the Prevention and Control of Healthcare Associated Infections. The Forum provides assurance that risks are appropriately managed and that appropriate arrangements are in place to achieve a safe clinical environment.

The membership of the forum is multidisciplinary and includes representatives from The Office of Public Health at Dudley Metropolitan Borough Council and Public Health England. This forum provides assurance to The Board that the infrastructure for infection prevention and control is in place. In addition to this there is representation from the Trusts private finance initiative partners.

5.0 SURVEILLANCE

The Department of Health requires mandatory surveillance of:

1. MRSA positive blood cultures (bacteraemia)
2. *Clostridium difficile* toxin positive results
3. MSSA positive blood cultures (bacteraemia)
4. E-coli positive blood cultures (bacteraemia)

The above are reported monthly via HCAI data capture system which is managed by Public Health England and signed off on behalf of the Chief Executive.

5.1 MRSA Bacteraemia

The NHS has set a zero tolerance approach to MRSA bloodstream infections. For the purposes of this report **zero** cases have been attributed to The Trust.

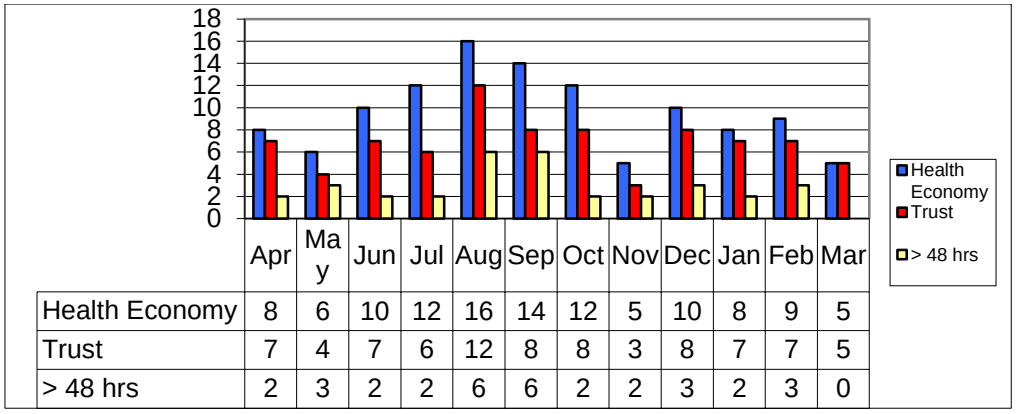
5.2 Clostridium difficile

The Trust reports all of Clostridium difficile toxin positive cases identified in the hospital laboratory. For this financial year we have reported a total of 33 cases of Clostridium difficile of which 13 have been recognised as being due to a lapse of care and attributed to the Trust. Themes for lapses in care were identified as antimicrobial stewardship, a reduction in the cleaning score and a delay in isolation of patients within 2 hours of onset of diarrhoea.

The antimicrobial pharmacist Additional training sessions have also been carried out through the year by the antimicrobial pharmacist. The Trust increased the cleaning audits in the affected areas and performance managed the issues identified via the PFI contract. The Infection Prevention and Control Team undertook targeted educational sessions to emphasise the requirement for timely isolation. The other cases are related to external factors.

The Trust objective was to have no more than 29 cases where a lapse in care was identified. All cases were scrutinised using a robust root cause analysis process in conjunction with the Office of Public Health Dudley Metropolitan Borough Council and Dudley CCG. The learning from these cases was shared across the organisation in order to improve practice.

The table below demonstrates the number of Clostridium difficile positive cases identified at The Dudley Group NHS Foundation Trust for this reporting period.

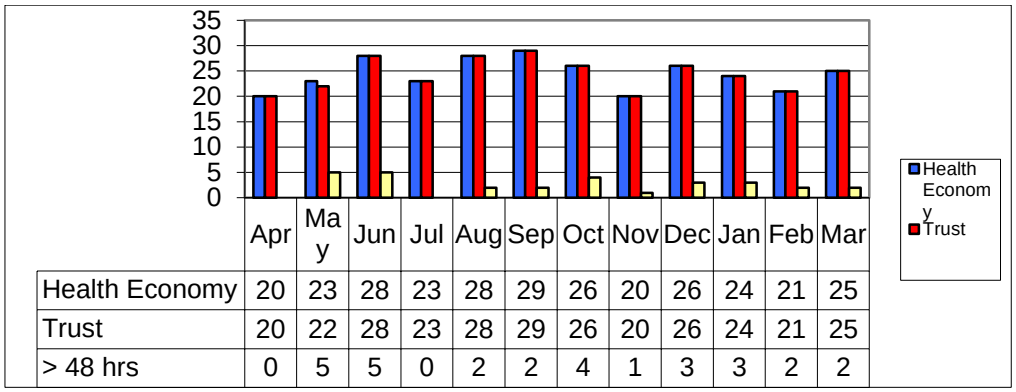


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	6	10	12	16	14	12	5	10	8	9	5
Trust	7	4	7	6	12	8	8	3	8	7	7	5
> 48 hrs	2	3	2	2	6	6	2	2	3	2	3	0

5.3 Escherichia Coli Bacteraemia.

Approximately three-quarters of E. coli bacteraemia occur before people are admitted to hospital. The Trust continues to fulfil its mandatory requirement and contributes to this enhanced national surveillance.

The table below demonstrates the number of E. coli positive cases identified at The Dudley Group NHS Foundation Trust for this reporting period. As of April 2017 the Trust will undertake enhanced surveillance of E. Coli bacteraemia as part of a whole health economy ambition to reduce Gram-negative bloodstream infections.

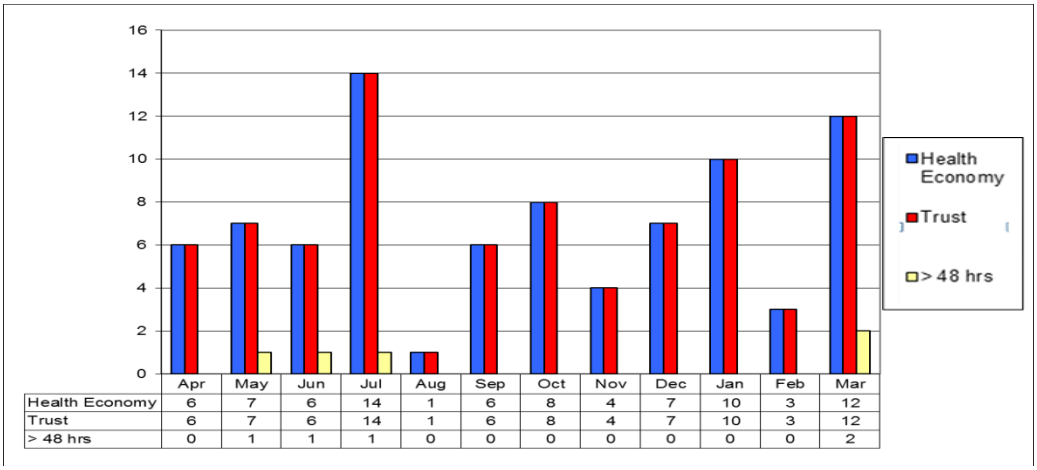


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	20	23	28	23	28	29	26	20	26	24	21	25
Trust	20	22	28	23	28	29	26	20	26	24	21	25
> 48 hrs	0	5	5	0	2	2	4	1	3	3	2	2

5.4 Meticillin Sensitive Staphyloccous aureus (MSSA) Bacteraemia.

MSSA is a type of bacteria which lives harmlessly on the skin and in the nose, in approximately one third of people. MSSA usually causes no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. surgical wounds. The Trust continues to fulfil its mandatory requirement and contributes to this enhanced national surveillance

The table below demonstrates the number of MSSA bacteraemia cases identified at The Dudley Group NHS Foundation Trust for this reporting period. 6 of the cases had been inpatients for more than 24 hours. One patient was admitted with sepsis, one was related to soft tissue infection. All patients had peripheral lines in situ. The Infection Prevention and Control Team delivered training in conjunction with the clinical skills team to reinforce the policy on the insertion and ongoing care of peripheral lines.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	6	7	6	14	1	6	8	4	7	10	3	12
Trust	6	7	6	14	1	6	8	4	7	10	3	12
> 48 hrs	0	1	1	1	0	0	0	0	0	0	0	2

6.0 SURGICAL SITE SURVEILLANCE

In April 2004 it became a mandatory requirement to carry out surveillance in Orthopaedic surgery. Each Trust should conduct surveillance for at least one orthopaedic category for one period within the financial year. The four orthopaedic categories are:

- Hip Replacements
- Knee Replacements
- Repair of Neck of Femur
- Reduction of long bone fracture

Public Health England undertakes surveillance of surgical site infections annually. In total there are 17 surgical categories, including mandatory orthopaedic data. The data for the remaining categories are submitted on a voluntary basis.

The table below identifies the mandatory surveillance undertaken in 2016/2017 at the Dudley Group Foundation Trust. One surveillance period was undertaken from July to September 2016 focusing on knee replacement surgery and then a further surveillance period was undertaken in October to December 2016 focusing on hip replacement surgery.

Type of Surgery	Total number of Operations	Total number of Inpatient/ readmissions SSI's	Trust Percentage Rate	National average percentage rate.
Knee Replacement Surgery (July - September 2017)	95	1	1.1%	1.5%
Hip Replacement Surgery (October - December 2017)	87	0	0%	1.1%

One surgical site Infection was identified during the knee replacement module and was identified as a superficial infection following the patient's readmission to hospital.

Following microbiological swabbing staph aureus (MSSA) was identified in the patients wound.

No cases of surgical site infection were identified in the hip replacement surveillance period October to December 2017.

7.0 OUTBREAKS / PERIOD OF INCREASED INCIDENCE (PII)

Untoward Incidents and Outbreaks 2016-17
Incidents and outbreaks occurring in 2016/17 were reported to the hospital Infection Prevention and Control Forum throughout the year. Different outbreaks/incidents demand different responses but are managed with precision and collaborative working between the multi-disciplinary teams across the health economy. Please see information below for more detail.

Clostridium Difficile
In August 2016 there was a period of increased incidence on the medical high dependency ward, during which 2 patients had confirmed Clostridium Difficile. A thorough investigation was undertaken and the area was deep cleaned and staff education was delivered by the Infection Control team. Further laboratory testing confirmed that the cases were not linked. There have been no further related cases on the ward to date.

In October 2016 there was a period of increased incidence on the gastroenterology ward, during which 2 patients had confirmed Clostridium difficile. A thorough investigation was undertaken; no lapses in care were identified. Areas on ward were deep cleaned. Further laboratory testing confirmed that the cases were not linked. There have been no further related cases on the ward to date.

In September 2016 Clostridium difficile was reported as a cause of death on a patient's death certificate, as required from Public Health England a thorough investigation was undertaken and working closely with the Office of Public Health, education was delivered to General practitioners regarding antimicrobial prescribing.

In February 2017 there was a period of increased incidence on a surgical ward during which 2 patients had confirmed Clostridium Difficile. A thorough investigation was undertaken and ward cleaning audits were increased and staff education was delivered by the Infection Control team. Further laboratory testing of samples was inconclusive. There have been no further related cases on the ward to date.

Norovirus
Norovirus is a self-limiting diarrhoea and vomiting bug that usually lasts 48-72 hours and is more prevalent in the winter months.

In January 2017 on our Elective / Trauma Orthopaedic ward Norovirus was confirmed. 1 patient was confirmed positive and there were several unconfirmed cases. In order to contain spread the ward was closed for 2 days, with deep cleaning undertaken. Symptoms were reported promptly and outbreak contained therefore a short duration with good outbreak education and management at ward level. Signage was in place at

key entrances and the Infection Prevention nurses were available weekends to support staff while on site testing helped with prompt identification of the virus.

Tuberculosis (TB)
In March 2017 there was an incident of pulmonary TB admitted to an open ward. Contact tracing of staff and patients was completed and no transmission was identified.

Outbreak Neonatal Unit
In December 2017 laboratory testing identified an organism that has potential to harm neo-nates; therefore screening of all other babies within the unit was undertaken. To prevent further spread or any harm, the unit closed to external transfers from other hospitals until further laboratory testing had been completed, this was inconclusive. Enhanced ward cleaning and close collaboration with Public health England ensured the unit re-opened promptly.

8.0 AUDIT

Saving Lives Audit

The Saving Lives programme (DH, 2008) was introduced to support healthcare providers in reducing healthcare associated infections. It identified high-impact interventions (HIIs) relating to areas of clinical practice where patients are at increased risk of infection, with the aim of reducing variations in care. The Saving Lives Audit within the Trust is undertaken on a monthly basis.

This system can be accessed by Heads of Nursing, Matrons and Lead Nurses enabling users to review and monitor individual performance.

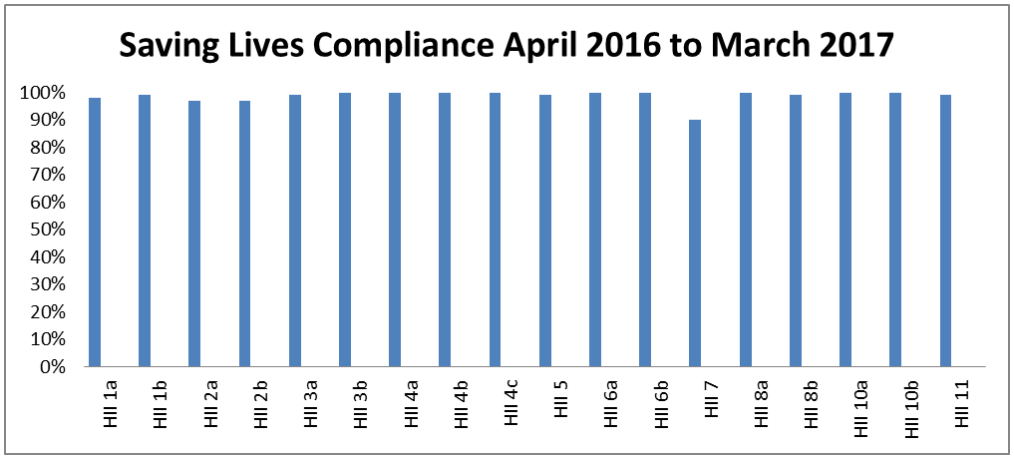
Areas that submit scores of less than 95% are required to complete an action plan to identify how they will rectify the overall score and how this will be cascaded across the areas.

The HIIs audits include:

- HII 1a CVC Insertion
- HII 1b CVC Ongoing Care
- HII 2a Peripheral Lines Insertion
- HII 2b Peripheral Lines Ongoing Care
- HII 3a Renal Dialysis Insertion
- HII 3b Renal Dialysis Ongoing Care
- HII 4a Surgical Site Pre Op
- HII 4b Surgical Site Intraoperative
- HII 4c Surgical Site Post Op
- HII 5 Reducing Ventilation associated pneumonia
- HII 6a Urinary Catheter Insertion
- HII 6b Urinary Catheter Ongoing Care
- HII 7 C.difficile
- HII 8a Clinical equipment Decontamination Infect

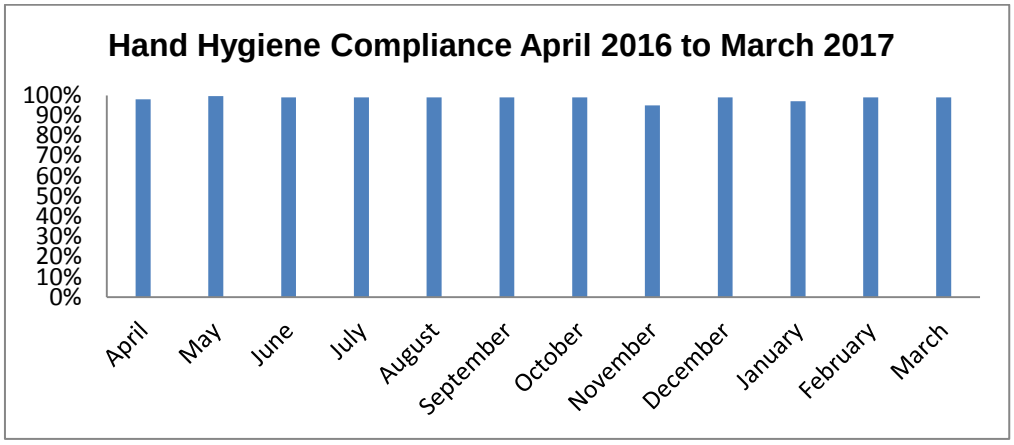
- HII 8b Clinical equipment Decontamination Non Infected
- HII 10a Chronic Wounds: Wound care
- HII 10b Chronic Wound Patient Management
- HII 11 Enteral Feeding

The graph below demonstrates overall Trust compliance with Saving Lives Audits for the year April 2016 to March 2017.



Hand Hygiene Audit

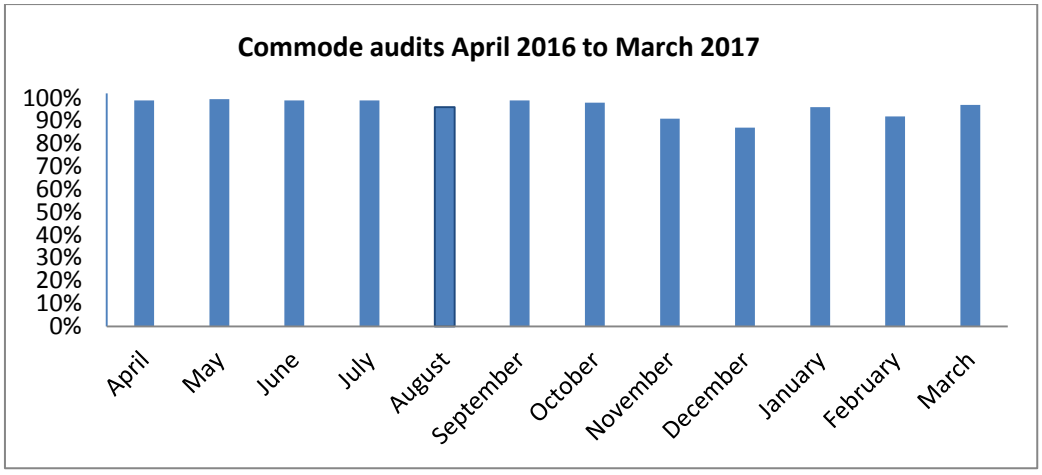
Hand hygiene continues to be a top priority in the Trust. Monthly audits of hand hygiene compliance are undertaken. The Trust target for hand hygiene compliance rates is 95%.



Commode Audit

Monthly commode audits are undertaken to ensure the condition and the cleanliness of commodes are monitored. Broken commodes are removed and replaced as necessary.

The graph below demonstrates overall Trust compliance for commode audits for the year April 2016 to March 2017.

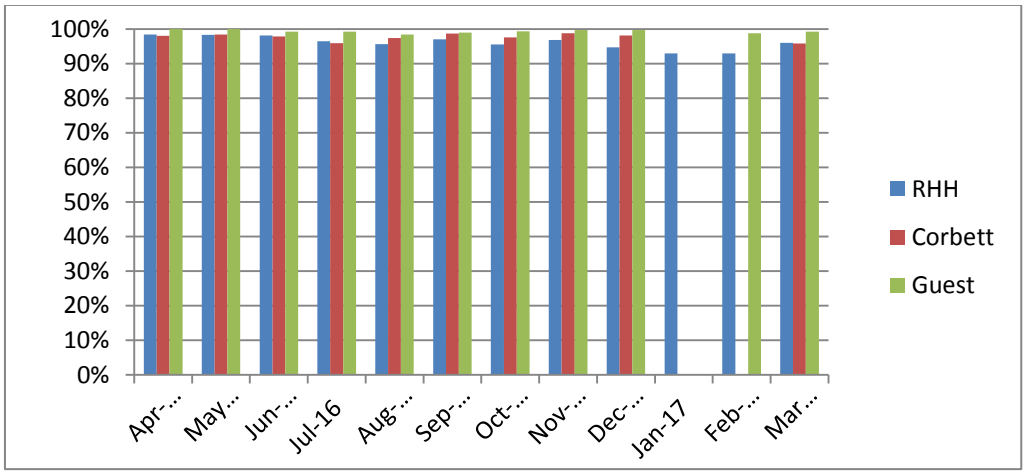


9.0 ESTATES & FACILITIES

9.1 Environmental Audits

The Trust recognises its duty to provide safe and clean environments where patients, staff and other visitors can expect to be protected from the risk of Infection. The environmental cleaning service is provided by Interserve (Facilities Management) Ltd (IFM) as part of the Trusts PFI contract with Summit Healthcare (Dudley) Ltd (Summit). The contract is managed by the Trusts Facilities and Property Development Department. Environmental audits are undertaken by the Trust Auditors in partnership with IFM and clinical staff.

The table below outlines the weighted cleaning scores for The Trust for this reporting period.



Following the successful trial of a combined Housekeeper/Domestic Service on Wards B4 and C5, the service was rolled out to the majority of inpatient areas at Russells Hall Hospital commencing September 2016. The service was designed to improve the coverage and responsiveness of both the environmental cleaning and inpatient catering service delivered by IFM at ward level. However, shortly after the full introduction of this service, the Trust Facilities Management Audit Team identified deterioration in cleaning scores across a number of areas. In response to this the Trust increased the cleaning audits in the affected areas and applied the performance management mechanisms

within the PFI contract. This resulted in cleaning scores improving which continue to be closely monitored and further action taken where necessary.

The Trust utilises hydrogen peroxide vapour as an additional method of cleaning for areas where infections have been identified. A machine releases a fine vapour (Hydrogen peroxide 4.9%) into the atmosphere in a sealed environment. The vapour kills a wide variety of micro-organisms. There is an on-going rolling programme of fogging in clinical areas.
Discussions are currently underway with Summit and IFM to establish costs to transfer the Hydrogen peroxide vapour service into the PFI Contract

9.2 Place 2016

Patient-Led Assessments of the Care Environment (PLACE) is a system of assessing the non-clinical aspects of patient care and replaced Patient Environment Action Team (PEAT) inspections as from April 2013. All Trusts are required to undertake these inspections annually to a prescribed timescale.

As the name suggests the PLACE team is led by Patient Assessors, who make up at least 50 per cent of the assessment team with the remainder being Trust and Summit Healthcare Staff. The inspection covers wards, outpatient areas, communal areas and external areas and generates scores under the following categories:

- Cleanliness
- Food
- Privacy, Dignity and Wellbeing
- Condition Appearance and Maintenance
- Dementia
- Disability

PLACE by its very nature is a snap shot of one day and can be influenced either way by what is seen on the day where ultimately the Patient Assessors can decide what areas are assessed. At the end of the assessment period, Patient Assessors are required to complete their own assessment form on how the overall assessment has been undertaken. This includes questions such as were their views taken on board and was sufficient time given to undertake the assessment etc.

The PLACE Scores for 2015 / 2016 were as follows.

	2015 Score	2016 Score
Cleanliness	99.06%	99.14%
Food (Combined)	86.08%	80.74%
Food (Organisational)	75.19%	83.46%
Food (Ward)	88.47%	80.01%
Privacy, Dignity and Wellbeing	85.87%	84.01%
Condition, Appearance and Maintenance	94.97%	96.59%
Dementia	74.13%	80.95%

10.0 ANTIBIOTIC STEWARDSHIP

Antimicrobial Stewardship Report 2016-17
This paper provides an update and an assurance of compliance with standards set out by Health and Social care IPC code of practice for Antimicrobial stewardship, Department of Health "Start Smart then Focus" and NICE NG15 (2015) Antimicrobial Stewardship: systems and processes for effective antimicrobial medicines use.

CQUIN: Antimicrobial Resistance and Antimicrobial Stewardship
For 2016-17 Dudley participated in the national CQUIN: Antimicrobial Resistance and Antimicrobial Stewardship. The goal of this CQUIN was to reduce antibiotic consumption with a focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours. Indiscriminate and inappropriate antibiotic prescribing has been identified as a key driver for antibiotic resistance therefore the CQUIN aimed to reduce total antibiotic usage and usage of key broad-spectrum antibiotics and ensure antibiotics are appropriately reviewed after initiation.

The antibiotic consumption targets and local achievements are detailed in table 1.

Table 1 (based on Fingertips AMR data Aug 2017)

Indicator (per 1000 admissions)	Target reduction	Reduction achieved
Total Antibiotic consumption	1%	6%
Total carbapenem consumption	1%	1.9%
Total piperacillin / tazobactam consumption	1%	22%

Dudley also achieved all four milestones for antibiotic review within 72 hours, with a final result of 90.2% of antibiotic prescriptions receiving a review within 72 hours.

In order to further the excellent achievements to date, the Trust has recruited an additional sepsis nurse and antimicrobial pharmacist to support initiatives to improve sepsis and stewardship.

Prescribing Standards
Compliance with antimicrobial guidelines continues to improve at Dudley. For Q4 of 2016/17, the Trust achieved 92% compliance with antimicrobial guidelines, an increase from 86% in the previous year.

Documentation of indication and stop/review dates is monitored regularly. Documentation of indication on the drug chart is 76% (regional average 73%) and duration/review date is 60% (regional average 62%).

Antimicrobial Consumption
For data collected by quarterly point prevalence surveys, prevalence of antibiotic use was 39% in Q4 2016-17 (**down 10%** on Q4 2015-16) and IV antibiotic usage was 17% (**down 33%** on Q4 2015-16). 40% of these are on IV antibiotics for longer than 72 hours. The regional average for IV antibiotic prevalence is 20%, therefore a figure of 17% at Dudley represents prudent use of IV antibiotics. Due to the much smaller

number of patients being initiated on antibiotics and receiving intravenous antibiotics, a 40% continuation in IV antibiotics is representative of those who most need to continue with IV therapy. The prevalence of patients on antibiotic courses longer than 7 days is just 5.3% in Dudley compared with a regional average of 7.3%.

When compared with National consumption data reported on Public Health England Fingertips, Dudley falls in the 2nd lowest percentile for total antibiotic usage (4197 Defined Daily Doses (DDDs)/1000 admissions vs. 4656 DDDs/1000 admissions for Dudley and national average, respectively).

National consumption compared with 17 peers using Define benchmarking software shows DGH **1%** below the mean for IV antibiotics per 1000 Trust beds for 2016-17. DGH are **6%** below the mean for higher Clostridium difficile risk antibiotics.

Updated/new Guidelines
Several new guidelines were added in 2016-17 including an antifungal therapy guideline, a sepsis first dose guide and maternal sepsis. Many of the existing guidelines were reviewed and updated to reduce broad spectrum antibiotic usage and address global antibiotic shortages. Guidance is produced between the microbiology and pharmacy departments with input from the relevant specialties. Clinician engagement in guideline compliance is clear from the excellent rate of compliance demonstrated in the audits.

Education and Training
Mandatory training for clinicians in antimicrobial prescribing and stewardship continues to take place. All doctors new to the Trust are provided with antimicrobial training at induction. Better Training Better Care for FY1 and FY2 doctors in Antimicrobial Prescribing received excellent feedback from the participants. Additional training sessions have also been carried out through the year when guideline changes have occurred.

11.0 EDUCATION AND TRAINING

Mandatory Training
Mandatory Training is training that has been identified by the trust as those that cover the risk management subjects that are required by all employees.

Infection Control is identified as a mandatory core subject that all employees are required to receive. The Infection Control training is required on a 3 yearly basis and has a Key Performance Indicator (KPI) of 90%.

In order to support staff with training the DGFT are committed to developing a 70/20/10 learning approach. The model provides a framework of learning opportunities; this is broken down as indicated below:

70% - Experience and experiential learning on the job through day to day tasks/activities
20% - Learning from peers and colleagues within a social exposure, this could be within a team environment or learning from those that are more experienced
10% - Learning from specific courses or education programs

Infection Control Team delivers training sessions during Trust induction and Mandatory refresher training each month to various staff groups across the Trust. Following the session there is a requirement for all staff to complete a competency test, and the pass rate for this is 80%.

Staff also have access to an eLearning module for Infection control which can be located on the Learning and Development Page of the hub. It is also necessary for staff to complete a competency test if they choose to complete the session via this route and again the pass rate is 80%.

The table below indicates the mandatory training figures for Infection Prevention and Control the period 2016/2017. In order to support wards and departments to achieve the KPI this year, additional mandatory training sessions have been commenced so that staff can attend on Wards and departments in order to complete their mandatory infection control training.

	Infection Control – Clinical	**Infection Control – Non Clinical**
Division	>=90% >=80%	>=90% >=80%
Corporate / Mgt	80%	88%
Medicine & Integrated Care	83%	88%
Surgery	82%	89%
Trust Compliance	**82.8%**	**88.6%**

12.0 POLICIES

The Infection Prevention and Control Team have an on-going programme of policy. All policies are reviewed in consultation with Public Health England, The Office of Public Health in Dudley and Dudley CCG.

Policies reviewed:

- Decontamination and Decontamination of Medical Devices
- MRSA Screening. Emergency and Elective Admissions Policy

13.0 CONCLUSION

The prevention of healthcare associated infection remains a top priority for the public, patients and staff. All staff are targeted by education and training programmes alongside clinical visits with the aim to improve clinical practice, the healthcare environment, patient safety and ultimately the patient experience.

The Infection Prevention and Control Team do not work in isolation and the commitment for infection prevention and control that is demonstrated at all levels within the organisation is crucial to maintain high standards in the future.

Acknowledgement of thanks for contributors: Miss A Murray, Matron Infection Prevention and Control, Mr A Rigby, Head of Facilities Services and Miss D Stacey, Antimicrobial Pharmacist.

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on the 7th September 2017

TITLE:	**Guardian of safe working report**		
AUTHOR:	**Mr Babar Elahi – Guardian of safe Working Hours**	**PRESENTER**	**Mr Babar Elahi – Guardian of safe Working Hours**

CORPORATE OBJECTIVES:

SO2: **Safe and Caring Services**
SO4: **Be the place people choose to work**
SO5: **Make the best use of what we have**

The report covers the following elements:

- Guardians quarterly report with ongoing challenges
- Progress to date

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: Implementation of revised JD contract may adversely impact on rotas**
	Risk Register: Y COR102		**Risk Score: 16**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links to safe, caring and well led domains**
	Monitor	**N**	**Details:**
	Other	**Y**	**Details: national requirement for effective guardian role**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the actions taken by the Trust and its appointed guardian of safe working.

The Dudley Group NHS
NHS Foundation Trust

Board of Directors

Guardian of Safe Working Report September 2017

Purpose

To give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

This paper provides a summary of the following areas related to JDT and the 2016 TCS:

- Challenges
- Exception reports
- Fines
- Vacancies (data provided by Medical Work Force Department)
- Locum bookings (data provided by Finance Department)

Background and Links to Previous Papers

The role of Guardian of Safe Working Hours (GSW) is to:

- Ensure the confidence of doctors that their concerns will be addressed
- Require improvements in working hours and work schedules for JDTs
- Provide Boards with assurance that junior medical staff are safe and able to work, identifying risks and advising Board on the required response
- Ensure the fair distribution of any financial penalty income, to the benefit of JDTs.

This is the third quarterly GSW report and covers the period of 15th May 2017 to 17th August 2017. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish his role in the Trust and build relationships.

In August, 2017, 165 junior doctors in the Trust transferred onto the new contract. By the end of 2017 all junior doctors will be on the new contract. The table below shows the number of junior doctors posts which converted to the new contract. The picture will change over the coming year until all the junior doctors have transitioned onto the new contract.

Site	No of posts which converted in December 2016	No of posts which converted in February 2017	No of posts which converted in April 2017	No of posts which converted in August 2017
RHH	27	4	30	104

Since the Guardian of Safe Working is the Chair of Guardians of Safe Working for West Midlands, he can comment that The Dudley Group are performing well above other organisations.

Challenges

Engagement

Engagement with the junior doctor workforce is improving. The Guardian is following his strategy to engage junior doctors, which involves.

- Introduction to Guardian and his role by attending Junior Doctor Induction Day
- Attending junior doctor forum arranged by Postgraduate Clinical Tutor
- Attending junior doctors' operational forum
- Creating a dedicated Guardian email in the Trust
- Regular communication to junior doctors through emails
- Using Trust HUB to advertise important information to junior doctors

Since the last Board report, there has been a marked improvement in the engagement by the Educational Supervisors (ES) and Clinical Supervisors (CS) towards exception reports. As an outcome of last board report, the Trust Chief Executive has taken keen interest towards ES and CS dealing with exception reports in timely fashion. Guardian would like to thank the Chief Executive for her kind support. We have managed to close all outstanding exception reports related to working hours. Guardian would like to thank Senior Trust Medical Managers, who have personally contacted CS and ES, with pending exception reports and helped to resolve all outstanding exception reports.

Trust Exception Reporting Policy

Guardian in collaboration with the medical workforce department has helped draft the trust exception reporting policy. This policy reflects the true spirit of the new junior doctors contract. It is awaiting its approval from JLNC.

Software System

As indicated in the previous Guardian reports, Allocate does not 'speak' to payroll and as a result all requests for additional payment for hours worked have to be administered manually. Both supervisors and juniors have provided poor feedback on its usage. This is a national issue with the software and we are working towards solutions to make it more effective.

Data Collection for Board Report

The Guardian quarterly board report requires data, which has to be provided by guardian office, medical workforce and finance. The Guardian has held meeting with HR and Finance department to streamline this in an orderly manner. It has been agreed that data for board report will be provided at least a month in advance to the guardian office for it to be presented to the Board in time.

Delay in Payments to Junior Doctors

There has been some delay in payments to junior doctors for overtime and fines. This has been partly due to delay in exception reporting policy and payment methods. These are teething issues and as we progress with this new contract. I am confident that this will be more effective and more streamlined in the future**.**

Junior Doctors Forum

The Guardian junior doctor forum remains a success with good engagement by juniors. We have been able to address their on-going issues. The Trust Chief Operating Officer attended our last forum. Juniors were keen not only to attend but to participate in discussions towards various rota issues. The success of this forum is attributed towards advertisement of the forum on the hub and attendance by senior medical and non-medical members of the forum.

Exception Reports and Fines.

From 15h May to 17th August 2017, we have received 6 exception reports by 2 doctors:

- None resulted in guardian fines
- There were no Immediate Safety Concerns reported.
- 2 exception reports have been completed with no further action agreed by the supervisor and the junior doctor.
- 4 from the same doctor are still pending. Delay may be partially due to leave and change in rotation. Medical Director has already intervened.

Exception Reports by Department – From 15th May – 17th August 2017 total = 6

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
None	6	2	4	Medicine

Exception Reports by Grade - All FY1s

All FY1	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
	6	0	2	4

Response Time

Within 48 hours	Within 7 days	Longer than 7 days	Still open
0	0	2	4

Guardian Fines – FY1 GENERAL SURGERY

It was identified on 28th April 2017 that Trainees were working a non-compliant Rota due to lack of compensatory rest days following a weekend of twilight duties. The Rota that was put together by the Department did not reflect the Rota that was built in the Allocate Software, hence a breach of contract.

December 2016 – April 2017

Name	Twilight Shifts	Hours	4x Hourly Rate	Penalty to Dr (1.5x)	Fine to Guardian (2.5x)	Total Fine (£3)
Dr C	2	8	51.05	23.37	27.69	408.40
Dr M	2	8	51.05	23.37	27.69	408.40
Dr B	2	8	51.05	23.37	27.69	408.40
Dr A	2	8	51.05	23.37	27.69	408.40
Dr D	2	8	51.05	23.37	27.69	408.40
Dr F	2	4	51.05	23.37	27.69	408.40
Dr S	1	4	51.05	23.37	27.69	204.20
Dr L	1	4	51.05	23.37	27.69	204.20
Dr D	1	4	51.05	23.37	27.69	204.20
Dr C	1	4	51.05	23.37	27.69	204.20
Dr P	1	4	51.05	23.37	27.69	204.20
Dr O	1	4	51.05	23.37	27.69	204.20
					TOTAL	**£3975.60**

April 2017 – August 2017

Name	Twilight Shifts	Hours	4x Hourly Rate	Penalty to Dr (1.5x)	Fine to Guardian (2.5x)	Total Fine (£3)
Dr P	1	4	51.05	23.37	27.69	204.20
Dr R	1	4	51.05	23.37	27.69	204.20
Dr N	1	4	51.05	23.37	27.69	204.20
					TOTAL	**£612.60**

Total Fine Amount: £4588.20

Nodal point	Total hourly (x4) figure	Hourly penalty rate (£), paid to the doctor	Hourly fine (£), paid to the guardian of safe working hours
1	51.05	23.37	27.69
2	59.09	27.05	32.04
3	69.94	32.00	37.94
4	88.62	40.57	48.06

Guardian of Safe Working and Medical Director are working to avoid future breaches.

High level data

Number of doctors/dentists in training (total): **199**

Number of doctors/dentists in training on 2016 TCS (total): **165**

Numbers of doctors/dentists in training due to commence on the new contract in September/October: **30**

Admin support provided to Guardian: How many hours are allocated to Medical Workforce for Guardian? **NIL**

Hours Monitoring Exercise for doctors on 2002 TCS only

Hours monitoring exercises (for doctors on 2002 TCS only)					
Specialty	Grade	Rostered hours	Monitored hours	Banding	WTR compliant (Y/N)
ED	SHO Tier	Invalid Return	Unable to comment	N/A	N/A
ENT/T&O	SHO Tier	Invalid Return	Unable to comment	N/A	N/A
Gen Med	SPR Tier	Invalid Return	Unable to comment	N/A	N/A

Vacancies

Vacancies by month

Specialty	Grade	Month 1 - May	Month 2 - Jun	Month 3 – Jul
Diabetes	CMT	X	X	X
Diabetes	ACCS	X	X	X
Cardiology	Trust SPR		X	X
Cardiology	Trust SPR		X	X
Cardiology	GP Trainee	X	X	X
EAU	CMT	X	X	X
EAU	Trust SHO	X	X	X
EAU	Trust SHO	X	X	X
EAU	ST Higher	X	X	X
Renal	FY1	X	X	X
Renal	ST Higher	X	X	X
Stroke	GP Trainee	X	X	X

Stroke	ST Higher	X	X	X
Geriatrics	ST Higher	X	X	X
Geriatrics	GP Trainee	X	X	X
Geriatrics	GP Trainee	X	X	X
Geriatrics	CMT	X	X	X
Surgery	FY1	X	X	X
Surgery	FY2	X	X	X
T&O	FY2	X	X	X
Urology	Trust SPR	X	X	X
Plastics	Trust SPR	X	X	X
Ophthalmolo-gy	Trust SPR	X	X	X
ED	ST Higher	X	X	X
ED	ST Higher	X	X	X
ED	Trust SPR	X	X	X
ED	Trust SPR	X	X	X
ED	Trust SPR	X	X	
ED	ACCS	X	X	X
ED	Trust SHO	X	X	X
ED	Trust SHO	X	X	X
ED	Trust SHO	X	X	X
Respiratory	GP Trainee	X	X	X
Respiratory	GP Trainee	X	X	X

Rota Gaps per speciality per Grade as of 3rd August 2017

Speciality / Grade	FY1	FY2	ST 1-2	GPVTS	ST 3-8	Trust SHO	Trust Middle Grade	Total	Notes
Cardiology							2	2	1 further ST3-8 leaves from Sept
Diabetes	1							1	
Elderly Care	1		1	2	2	2		8	1 further ST3-8 on reduced duties due to illness. 1 GPVTS should return to work next week
EAU			1		1	3	1	6	1further Trust doctor leaves

									end Aug
Renal					1			1	1 further ST3-8 on reduced duties due to illness
ED				3	1	6?	2?	12	1 further GP in ED cannot do EPP; 1 ST3-8 has concerns. As per business case, figures uncertain
General Surgery	1		2					3	
Vascular Surgery			1					1	
T & O						1		1	
Obs & Gynae				1				1	
Paeds			1	1				2	
Psychiatry	1							1	
Total	**4**	**0**	**6**	**7**	**5**	**12**	**5**	**39**	

Locum Bookings - Bank

Locum Spend (Bank) by department/grade				
	Apr-17	May-17	Jun-17	TOTAL Q1
AMU				
FY1	£3,296	£6,618	£5,286	**£15,200**
FY2	£6,169	£15,061	£8,472	**£29,702**
GP ST	£5,311	-£2,265	£2,004	**£5,051**
SHO	£29,740	£23,417	£45,089	**£98,246**
Spec Reg	£12,590	-£17,159	£26,255	**£21,686**
ST (Higher)	£1,996	£7,348	£8,618	**£17,962**
ST (Lower)	£670	£0	£535	**£1,205**
Anaesthetics				
Spec Reg	£2,239	£3,397	£2,624	**£8,260**
ST (Higher)	-£299	£1,374	£2,635	**£3,710**
ST (Lower)	-£83	£7,458	£8,679	**£16,054**
Cardiology				
Spec Reg	£0	£4,904	-£21	**£4,883**
ST (Higher)	£0	£1,599	£420	**£2,019**
Chemical Pathology				
SHO	£0	£104	-£4	**£100**
ED				
GP ST	£0	£1,398	£0	**£1,398**
SHO	£20,886	£7,886	£17,516	**£46,289**
Spec Reg	£963	£821	£15,203	**£16,987**
ST (Higher)	£0	£2,807	-£96	**£2,711**
ST (Lower)	£1,492	£492	-£66	**£1,917**
Clinical Haematology				
FY1	£0	£0	£973	**£973**
Endocrinology				
SHO	£0	£0	£0	**£0**
ST (Higher)	£1,826	£2,603	£1,894	**£6,323**
ENT				
Spec Reg	£1,267	£600	£300	**£2,167**

ST (Higher)	-£4	£1,390	-£12	**£1,374**
ST (Lower)	£0	£0	£0	**£0**
Gastroenterology				
SHO	£2,603	£0	£726	**£3,329**
Spec Reg	£1,898	-£1,578	£7,495	**£7,815**
ST (Higher)	£4,432	£9,249	-£6,475	**£7,205**
General Surgery				
FY1	£407	£8,938	-£4	**£9,341**
SHO	£2,430	£211	£8,949	**£11,590**
Spec Reg	-£1,363	£1,105	£4,142	**£3,884**
ST (Lower)	£0	£0	£1,095	**£1,095**
ST (Higher)	£436	£4,621	-£3,551	**£1,505**
Max Facial				
SHO	-£21	£332	£1,013	**£1,323**
ST (Lower)	-£10	£326	-£5	**£312**
Obstetrics				
SHO	£5,221	£1,271	-£4,239	**£2,253**
Spec Reg	£3,007	£4,475	£4,047	**£11,529**
ST (Higher)	£0	£271	-£5	**£266**
ST (Lower)	£0	£0	£452	**£452**
Older People				
FY1	£0	£0	£0	**£0**
FY2	£835	£527	£136	**£1,498**
SHO	£2,257	-£18	£3,941	**£6,180**
ST (Higher)	-£8	£424	£1,318	**£1,734**
Paediatrics				
FY1	£0	£0	£678	**£678**
FY2	£0	£0	£0	**£0**
GP ST	£3,395	£366	-£898	**£2,863**
SHO	-£78	-£431	£4,043	**£3,534**
ST (Higher)	£0	£1,889	£1,691	**£3,580**
ST (Lower)	£0	£0	£0	**£0**
Renal				
FY2	£0	£565	£556	**£1,121**
SHO	£0	£2,373	-£2,034	**£339**
ST (Lower)	£0	£339	£448	**£787**
ST (Higher)	£0	£0	£0	**£0**
Rheumatology				
Spec Reg	£410	£1,687	£2,519	**£4,615**
ST (Higher)	-£7	£0	£424	**£416**
Stroke				
FY2	£0	£0	£0	**£0**
SHO	£4,592	£4,710	£6,914	**£16,216**
Spec Reg	£14,083	£21,811	£31,898	**£67,792**
T&O				
FY2	£2,270	£5,482	-£6,040	**£1,712**
SHO	£0	£0	£1,130	**£1,130**
Spec Reg	£0	£2,450	-£1,094	**£1,356**
ST (Higher)	£0	£300	£35	**£335**
ST (Lower)	£1,173	£1,684	-£17	**£2,841**
Urology				
ST (Higher)	£0	£540	£0	**£540**

Vascular				
FY1	£0	£1,695	-£20	**£1,675**
FY2	£0	£0	£0	**£0**
TOTAL	**£136,018**	**£145,468**	**£205,571**	**£487,057**

Locum Bookings - Agency

Locum Spend (Agency) by department/grade				
	Apr-17	May-17	Jun-17	TOTAL Q1
AMU				
SHO	-£50	£3,135	-£1,206	**£1,879**
Cardiology				
SHO	£2,088	-£589	£0	**£1,499**
ED				
SHO	£117,152	£173,589	£30,198	**£320,939**
ST (Higher)	£0	£11,604	£6,095	**£17,699**
Endocrinology				
SHO	£278	£245	£13,054	**£13,576**
General Surgery				
SHO	£0	£4,549	-£2,480	**£2,069**
ST (Higher)	£0	£0	£691	**£691**
Older People				
Spec Reg	£9,900	-£8,699	£26,699	**£27,900**
ST (Higher)	£0	£1,806	£600	**£2,406**
Paediatrics				
SHO	£154	£1,187	-£899	**£442**
Spec Reg	£10,064	£9,909	-£10,317	**£9,656**
Plastic Surgery				
Spec Reg	£8,292	£8,608	£0	**£16,900**
Renal				
SHO	£0	£0	£1,512	**£1,512**
Respiratory Medicine				
SHO	£0	£0	£256	**£256**
Stroke				
SHO	£0	£0	£9,994	**£9,994**
Urology				
Spec Reg	£0	£0	£26,207	**£26,207**
TOTAL	**£147,877**	**£205,344**	**£100,405**	**£453,626**

Next Steps

1. Continue to encourage wider junior doctor engagement by the Guardian.
2. Continue to use the Trust HUB to promote the role of Guardian in the Trust.

1. Conclusion

Guardian can give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

2. Recommendation
The Board are asked to read, note and take assurance from this report from the Guardian of Safe Working.

Author	**Babar Elahi** **Guardian of Safe Working**
Executive Lead	**Chief Executive**
Date	**22nd August 2017**

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 7th September 2017

TITLE:	Freedom to Speak Up (FTSU) Guardian Update		
AUTHOR:	Carol Love-Mecrow Deputy Chief Nurse/FTSU Guardian	**PRESENTER**	Derek Eaves, Professional Lead for Quality/FTSU Guardian

CORPORATE OBJECTIVE:
SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO4: Be the place people choose to work

SUMMARY OF KEY ISSUES:
This paper gives an update on:

- Numbers of concerns raised since the last report.
- Initiatives and developments to increase the profile of the role.
- Policy review
- Regional Guardian activity
- Reflections and future plans

IMPLICATIONS OF PAPER:			
RISK	**Y**		
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	Details: Well Led
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD			
Decision	**Approval**	**Discussion**	**Other**
		X	

RECOMMENDATIONS FOR THE BOARD:
To receive and note the latest developments with Freedom to Speak Up Guardian issues.

THE DUDLEY GROUP NHS FOUNDATION TRUST
Freedom to Speak Up (FTSU) Guardian update

Introduction

The appointment of the new Guardian, Derek Eaves, Professional Lead for Quality and the continued support in the role by Carol Love-Mecrow, Deputy Chief Nurse has provided an opportunity to review the current processes and reporting in line with recent developments related to the Freedom to Speak Up agenda.

Numbers of concerns raised since the last report.

Activity 1st June 2017- 30th August 2017	
Numbers	
Total number of concerns raised for this period	6
Raised anonymously	2
Raised confidentially	4
Concern	
Possible lapses in care	2
Bullying or a bullying culture	2
Recruitment processes	1
Unknown	1
Progress	
Required investigation	1
Concerns closed	2
In progress	3
Feedback	
Received	1
To be confirmed	5

Initiatives and developments to increase the profile of the role

The National Guardian Office has now been informed of the Trust's additional Guardian and the new contact details have been uploaded to the National Guardian Map. Photos of the FTSU Guardians *in action* have been taken and the Guardian office has confirmed that these will be used on the website.

The raising concerns web page on the HUB has been updated to reflect changes in the team and provide staff with clear guidance on how to safely raise a concern.

Internal communications regarding the Guardian role have been intensified to raise the awareness of staff of the importance of raising concerns.

A job description for the FTSU Guardian has been developed. **(Appendix 1)**
A FTSU 'factsheet' for staff has been drafted as has a guide for managers called: '*If a member of staff Raises a Concern and How to Handle It. A practical guide for senior staff and managers to develop an open culture and support speaking up'.*
The latter is presently being reviewed by the Human Resources Department. Once both have been completed they will be publicised and placed on the FTSU HUB page.

In conjunction with the Human Resources Department, the standard letter given to any staff member who is suspended from duty now contains reference to the availability of the FTSU Guardian.

Due to the large number of PFI staff who have patient contact the Guardians, through the Head of Development & Property Management, have made contact with Summit to assess how best to publicise the FTSU Guardian role to this group of staff. A response is awaited.

The National Guardian Office will shortly commence quarterly reporting on the numbers and types of concerns being raised at all Trusts. On September 1st the numbers for April to June 2017 will be published. Initial draft available figures suggest a wide range of cases from Trust to Trust. It is planned to give an update on the published figures at the meeting.

Policy review

The existing policy has now been reviewed and minor amendments made to include all recommendation made by the National Guardian Office. Making the policy more 'user friendly' in particular, giving examples of concerns to be raised and saying the Trust 'celebrates' staff raising concerns not just a duty or expectation. The policy is currently out for consultation and it is expected to be ratified at the next policy group.

Regional Guardian activity

Regional network meetings continue; having two Guardians means that we have committed to attending these meetings. The West Midlands FTSU network has submitted a nomination for the FTSU Network of the Year award recognising excellence in promoting and supporting the freedom to speak up agenda across Trusts involved in the network.

The FTSU network is now actively engaging with the Leadership Academy to ensure that the leadership needs of Guardians are met. The lead for the West Midlands Academy has given a presentation detailing what is available for Guardians within the network based on national feedback from Guardians. A programme of leadership skills and training that can be offered to the regional network is now being designed.

Reflections and future plans

The review of the existing FTSU processes and communications has refocused the FTSU agenda and with additional resource within the team we are able to move forward on initiatives that had previously been limited due to workload. Monthly meetings with the Chief Executive have commenced to enable both Guardians to discuss concerns being raised and to provide additional support for the Guardians.

Kathleen Denholm, CQC Inspector, has asked to meet the two Guardians and this has been arranged for the 11th September.

Appendix 1

Job Description

Why join The Dudley Group?

The Dudley Group has a strong reputation for leading the way in innovation and quality improvement. You could join our team of award winning staff who have received national recognition for their work. We constantly strive to offer the highest standards of care in line with our Trust values of care, respect and responsibility.

Job specifics

Job title:	Freedom to Speak Up (FTSU) Guardian
Hours:	As required
Responsible to:	Freedom to Speak Up Executive Lead/CEO

Job summary

Principal duties and responsibilities

Purpose of the role

The Freedom to Speak Up (FTSU) Guardian will work alongside trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

Duties and Responsibilities

The role of the FTSU Guardian is to:

Culture

- Develop and deliver communication processes to increase visibility of the Freedom to Speak Up Guardian amongst all staff.
- Promote local speaking up processes and sources of support and guidance, demonstrate the impact that speaking up is having in the organisation, and celebrate speaking up.
- Ensure that all 'frontline' staff are aware of, and have access to, support to help them speak up.

Process improvement

- Work with HR professionals and others to ensure that speaking up guidance and processes are clear and accessible, reflect best practice, and address any local issues that may hinder the speaking up process.
- Assess the effectiveness of Freedom to Speak Up processes and the handling of individual cases, intervening when these are failing people who speak up, and making recommendations for improvement.

Capability

- Assess the knowledge and capability of staff to speak up and to support people when they speak up.
- Ensure that all staff have the relevant skills and knowledge to enable them to speak up effectively, and those supporting, managing or investigating speaking up issues have the capability and knowledge to do this effectively.
- Ensure that appropriate items on speaking up are incorporated into induction programmes for all staff.
- Ensure that groups of staff and individuals who may find it difficult to speak up are given particular support.

Supporting staff

- Ensure that information and data are handled appropriately, and personal and confidential data are protected.

- Ensure that individuals receive appropriate feedback on how issues that they speak up about are investigated, and the conclusion of any investigation.

- Where necessary, give extra support, including 1-2-1 support, to people who are experiencing difficulty with speaking up, or those who are experiencing difficulty in handling or supporting someone who is speaking up.

Working with and challenging the Board

- Develop strong and open working relationships with the CEO, NEDs and other Directors, with direct access to Trust leaders as required.

- Attend board meetings regularly to report on Freedom to Speak Up activities. Reports should include assessment of issues that people are speaking up about (and trends in those issues), and barriers affecting ability of people to speak up. Particular attention should be given to concerns which may suggest a link to patient safety and quality.

- Hold the Board to account for taking appropriate action to create a Freedom to Speak Up culture, assess trends, and respond to issues that are being raised.

- Safety and quality

- Take immediate appropriate action when matters that people are speaking up about indicate that safety and quality may be compromised.

- Develop indicators to monitor trends and identify linkages between issues raised through people speaking up, and issues raised through other safety and quality routes.

NHS culture

- Take part in National Guardian Office activities and training, actively supporting fellow Freedom to Speak Up Guardians, developing personal networks and peer-to-peer relationships, contributing to wider networking events, and sharing and learning from best practice.

- Raise issues that cannot be resolved locally with the National Guardian’s Office, including where Trusts appear to be failing in their obligations.

- Keep abreast of developments and best practice, assessing their own development and training needs, and seeking support in addressing these.

Outcomes

The FTSU Guardian role is designed to contribute to achieving the following outcomes:

- A culture of speaking up is instilled throughout the organisation
- Speaking up processes are effective and continuously improved
- All staff have the capability to speak up effectively and managers have the capability to support those who are speaking up
- All staff are supported appropriately when they speak up or support other people who are speaking up
- The Board is fully sighted on, and engaged in, all Freedom to Speak Up matters and issues that are raised by people who are speaking up
- Safety and quality are assured
- A culture of speaking up is instilled throughout the NHS

There may also be a requirement to undertake other similar duties as part of this post in order to provide a quality service. These will be consistent with the level of responsibilities outlined above.

This job description may be reviewed from time to time in light of developments and may be amended in consultation with the post holder.

Please see your existing job description for other duties that are applicable to all staff across the Trust

Prepared by:	D. Eaves/C. Love-Mecrow
Date:	6th July 2017

Person Specification

Job title:	Freedom to Speak Up (FTSU) Guardian

Factors	**Essential**	**Desirable**	**How identified**
Trust Vision and Values Able to provide safe, caring and effective services because people matter We would expect your values and behaviours to reflect the Trust values of Care, Respect & Responsibility	Yes Yes		Interview
Independence Independent in the advice you give to staff and trust's senior leaders and free to prioritise your actions to create the greatest impact on speaking up culture Able to hold the Trust to account for: creating a culture of speaking up; putting in place processes to support speaking up; taking action to make improvements where needed; and displaying behaviours that encourage speaking up	Yes Yes		
Impartial Able to review fairly how cases where staff have spoken up are handled	Yes		
Empowered Take a leading role in supporting staff to speak up safely and to independently report on progress on behalf of a local network of 'champions' or as the single role holder	Yes		
Visible Available to all staff, particularly those on the frontline, and approachable by all, irrespective of discipline or grade	Yes		Interview
Influential Have direct and regular access to members of trust boards and other senior leaders	Yes		
Knowledgeable Up-to-date in Freedom to Speak Up matters and local issues, and able to advise staff appropriately about speaking up	Yes		
Inclusive Willing and able to support people who may struggle to have their voices heard	Yes		

Factors	Essential	Desirable	How identified
Credible Experience that resonates with frontline staff	Yes		
Empathetic Empathise with people who wish to speak up, especially those who may be encountering difficulties Able to listen well, facilitate constructive conversations, and mediate to help resolve issues satisfactorily at the earliest stage possible	Yes Yes		
Trusted Handle issues fairly, take action as necessary, act with integrity and maintain confidentiality as appropriate	Yes		
Self-aware Able to handle difficult situations professionally, setting boundaries and seeking support where needed	Yes		
Forward thinking Able to make recommendations and take action to improve the handling of cases where staff have spoken up, and freedom to speak up culture more generally	Yes		
Supported Have sufficient designated time to carry out your role, participate in external Freedom to Speak Up activities, and take part in staff training, induction and other relevant activities Access to advice and training, and appropriate administrative and other support	Yes Yes		
Effective Monitor the handling and resolution of concerns and ensuring clear action, learning, follow up and feedback.	Yes		Interview

Enclosure 11

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th September 2017

TITLE:	Complaints Report – Quarter 1 2017/18		
AUTHOR:	Jill Faulkner Head of Patient Experience	**PRESENTER:**	Siobhan Jordan Interim Chief Nurse
CORPORATE OBJECTIVE: SO1: Deliver a great patient experience			

SUMMARY OF KEY ISSUES:

Complaints received:

- 73 complaints received in Quarter 1 (Q1) – (1.39% increase compared to Q4, 2016/17 (72) and decrease from Q1 2016/17 of -13.1% (84))
  - Surgery Division 32 (36 Q4, 2016/17)
  - Medical Division 37 (39 Q4, 2016/17)
  - Other (Therapy Services) 4 (3 Q4,2016/167)
- All complaints were acknowledged within the statutory 3 working days after receipt.

Complaint themes:

- Medical Division themes
  - Clinical treatment in Emergency Department
  - Communication and attitude of staff
  - Admissions, discharges and transfer discharge
  - Clinical treatment – General Medicine
- Surgery Division
  - Poor communication and attitude of staff
  - Delays in ordering tests, treatment and making referrals
  - Delays/cancellations and waiting times
  - Patient care including nutrition and hydration

Complaint responses:

Thirty complaints have been responded to in Q1 and are broken down as follows:

- Medical Division 13 responses
- Surgery Division 15 responses
- Other (Therapies) 2 responses

Of those complaints responded to and closed in Q1 the outcomes were as follows:

- 1 upheld
- 21 partially upheld
- 8 not upheld

Of the 30 complaints closed in Q1, 4 remain dissatisfied and have requested further information/clarification and a Local Resolution Meeting (LRM)

Parliamentary Health Service Ombudsman (PHSO)

The trust received 3 new applications from the PHSO during Q1 – these are still being considered.

Four cases were completed and reported to the trust as follows:

- One not taken to formal investigation
- Two not upheld
- One partly upheld (recommendations completed – confirmation sent to complainant/PHSO). Learning and the action plan from this case has been disseminated to all ED staff and discussed at the quarterly governance meeting.

The Dudley Group
NHS Foundation Trust

Learning and actions from completed complaints – Section 2.8
The complaints report details all learning and actions from complaints that have been closed in Q1.

Complaints linked to serious incidents
There were no complaints linked to serious incidents in Q1.

IMPLICATIONS OF PAPER:			
RISK	**N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details:** Safe, effective and caring
	Monitor	Y	**Details:** Supports effective governance
	Other	Y	**Details:** The Local Authority Social Services and National Health Service (England) Complaints Regulations 2009

ACTION REQUIRED OF BOARD			
Decision	**Approval**	**Discussion**	**Other**

RECOMMENDATIONS FOR THE BOARD: To note the level of complaints activity during Quarter 1, 2017/18.

The Dudley Group
NHS Foundation Trust

Complaints Report – Quarter 1, 2017/18

1. Introduction

The Patient Experience team are the central hub within the Trust for the collation and reporting of patient feedback and continues to provide a first line response to patients, relatives and carers concerns. This is achieved through a number of reporting mechanisms including the Friends and Family Test (FFT), National Surveys, NHS Choices, Healthwatch, complaints and concerns.

By collecting and responding to patient feedback, The Dudley Group NHS Foundation Trust aims to embed a culture of continuous improvement within the organisation which will benefit patients, reward staff and enhance our reputation.

The Patient Experience team manages complaints in line with 'The Local Authority Social Services and National Health Service (England) Complaints Regulations 2009'. Complaints are acknowledged within 3 working days of receipt and investigated within 40 working days or a revised timescale agreed with the complainant by exception, only when the complaint becomes complex. The timescale for responding to complaints was increased to 60 working days for some complaints during Q1 because of capacity however this has been reduced back to 40 working days for all complaints in line with the trusts complaints policy.

During Quarter 1 (Q1), the Patient Experience Team received 73 complaints (1.39% increase) compared to Quarter 4 (Q4), 2016/17 (72) and a decrease (-13.1%) from Q1, 2016/17 (84).

The trust had 266,874 (trust wide) contacts in Q1 which equates to 0.0273 of patients/family's making a complaint.

2. Complaints

In Q1, the trust achieved a 100% response rate (letter) in relation to the acknowledgement timescale of 3 working days. All complaints received by letter, verbal, face to face or by email are verbally acknowledged where possible on the day of receipt, providing a prompt acknowledgement for patients, relatives and carers.

The Divisional performance of complaints is as follows:

- Surgery Division – 32 complaints
- Medical Division – 37 complaints
- Other (Therapy Services – now known as the Clinical Services Division) – 4 complaints

A comparison of complaints received by Division and service for Q1, 2017/18 and Q4, 2016/17 can be seen *in table 1 and 2* below:

Table 1

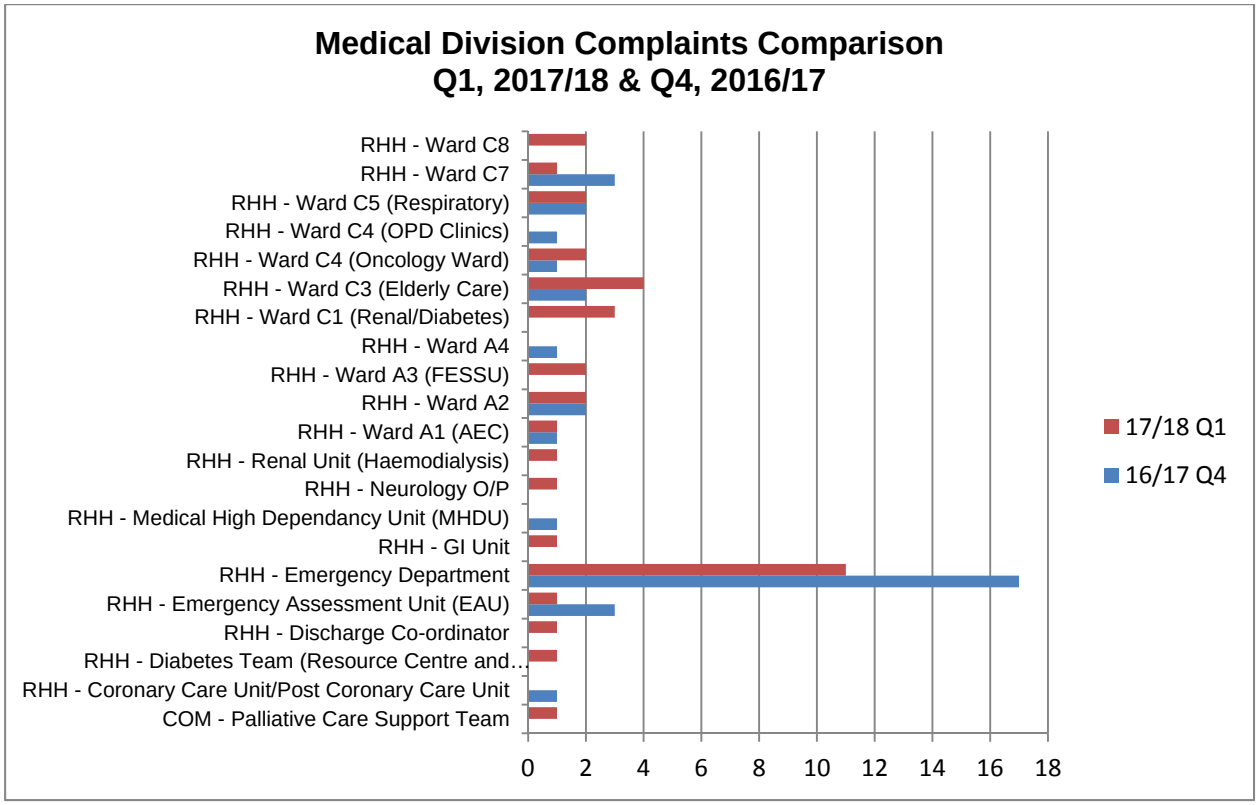
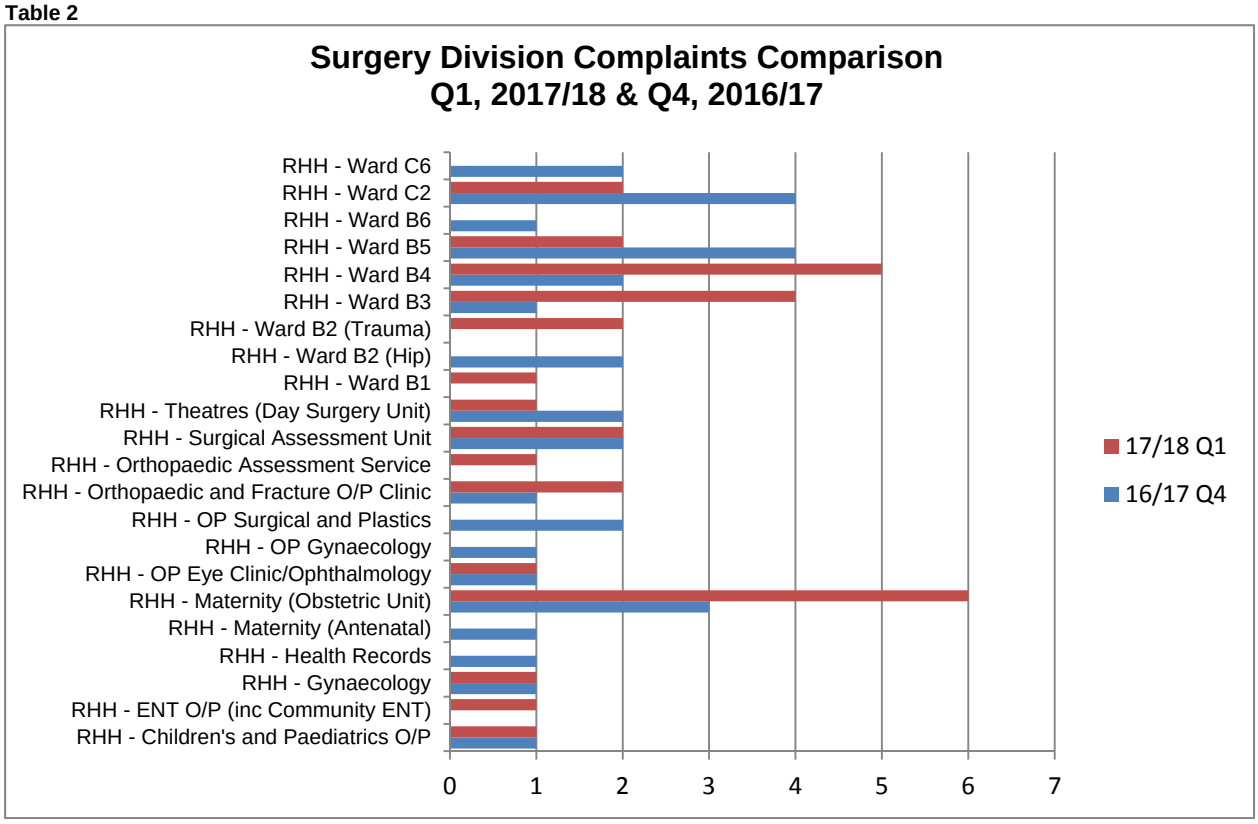


Table 2



The majority of complaints continue to relate to the Medical and Surgery Divisions within the trust.

2.1 Medical Division

During Q1, a total of 37 complaints were received by the Medical Division which indicates a slight decrease of -2.63% from Q4, 2016/17 (39).

Table 3 details complaints received by service:

Table 3

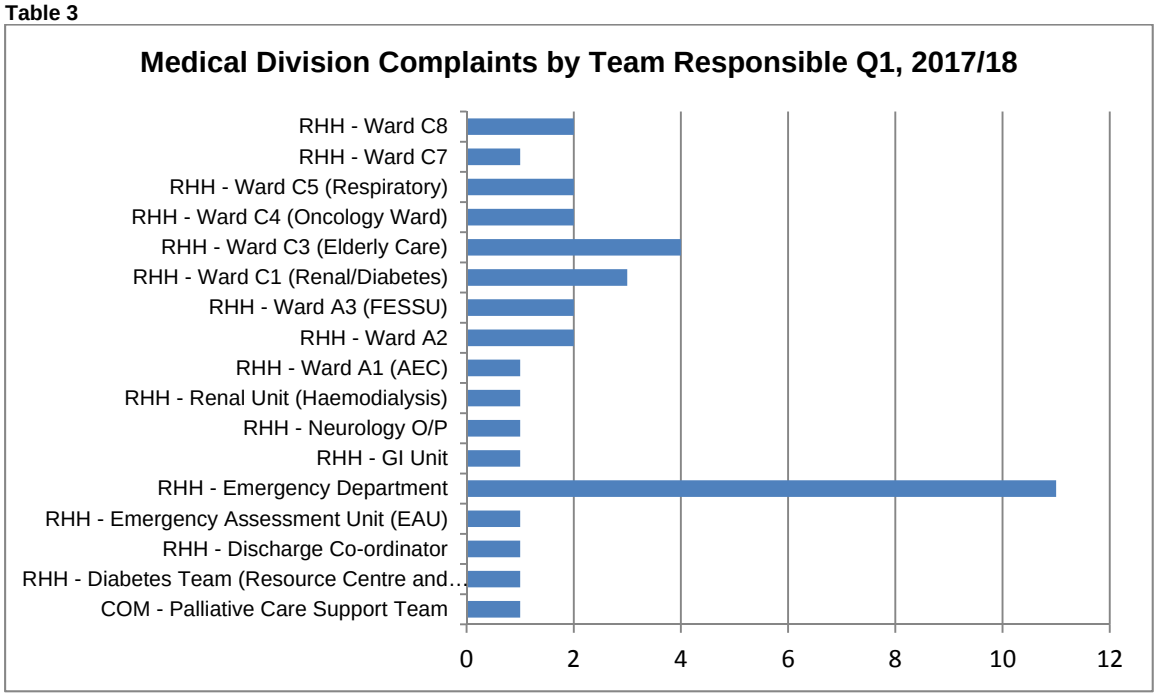
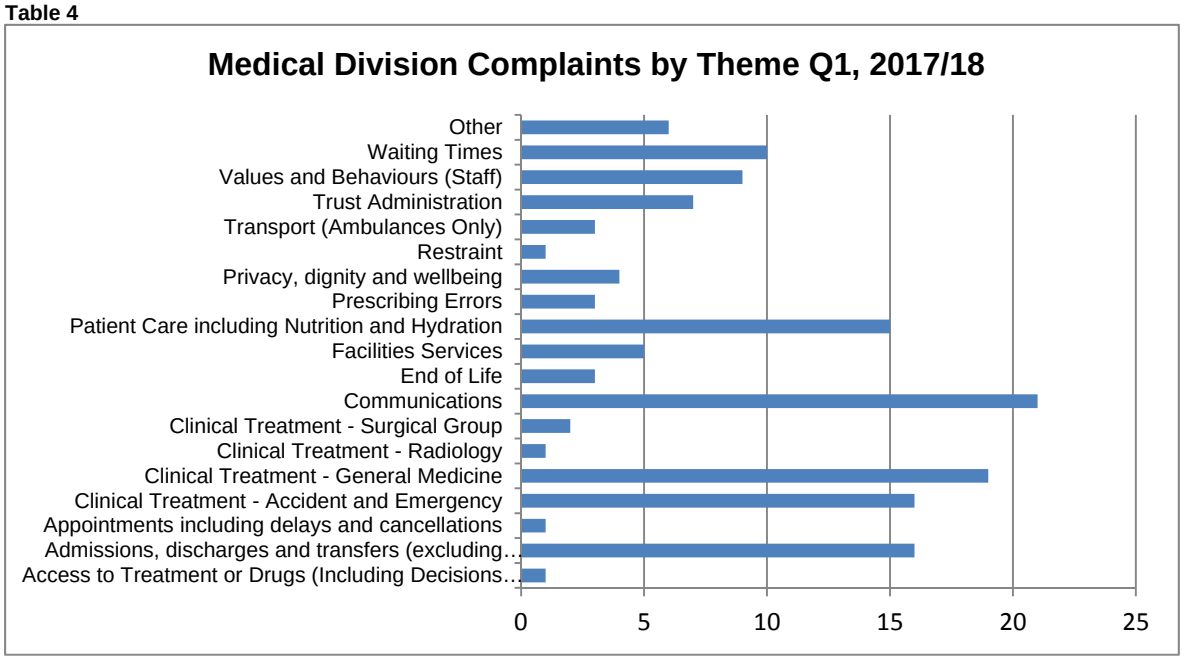


Table 4 details complaints received by subject.

Table 4



The significant themes identified relate to:

- Clinical treatment in the Emergency Department
- Communication and attitude of staff
- Admissions, discharges and transfers discharge
- Clinical treatment – General Medicine

Concerns raised through Q1 are as follows:

Poor communication is a recurring theme with many complainants. Patients and relatives feeling that staff are generally unsupportive and do not listen to their concerns or questions raised. There appears to be a lot of miscommunication when discussing a patient's condition. Staff are not checking that the family/patient understand what they are being told. Further concerns relate to patients being told they are to undergo a scan/test but it does not happen or is delayed due to lack of discussion/referral between different teams. This issue also resonates through the Surgery Division.

Patients are concerned they are not being discharged appropriately with many feeling it is too soon or adequate provisions and follow up are not in place.

Staff behaviour and attitude including staff appearing disinterested or having no time to assist patients is raised frequently. This makes patients feel they are a burden or will be 'told off' for requesting help. Patients have also reported that they have heard staff 'moaning' or discussing their colleagues in an unprofessional manner.

Basic care needs/hygiene and dignity particularly with the elderly are a concern for many families. Call buzzers are not being placed within easy reach for patients or go unanswered. Patients who are unable to go to the bathroom unsupported are unable to attract the attention of staff resulting in having to wait long periods of time for help.

Patients and relatives do not feel that ‘Intentional Rounding’ (care and comfort visits to patients on the wards every 2 hours) is in place. The feedback suggests that boxes are being ticked are saying they have not seen any staff carrying out the checks that have been signed for.

Loss of valuables/ property is a trust wide concern especially when disclaimers and property forms are not being completed and signed for. It is very difficult to undertake an investigation or reimburse a patient when there is no evidence that the items/money existed in the first place.

2.2 Surgery Division

During Q1, a total of 32 complaints were received by the Surgical Division which indicates a -11.11% decrease from Q4, 2016/17 (36). Further analysis has identified that Maternity, General Surgery and Paediatrics/Neonatal is a recurring area of complaints.

Table 5

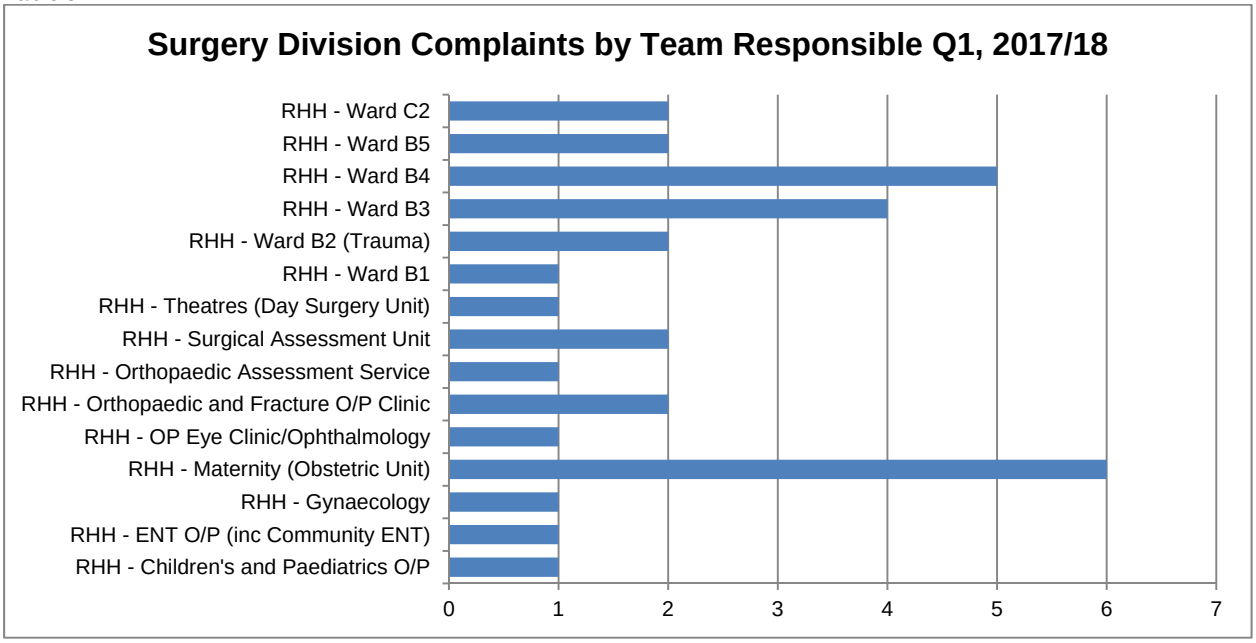
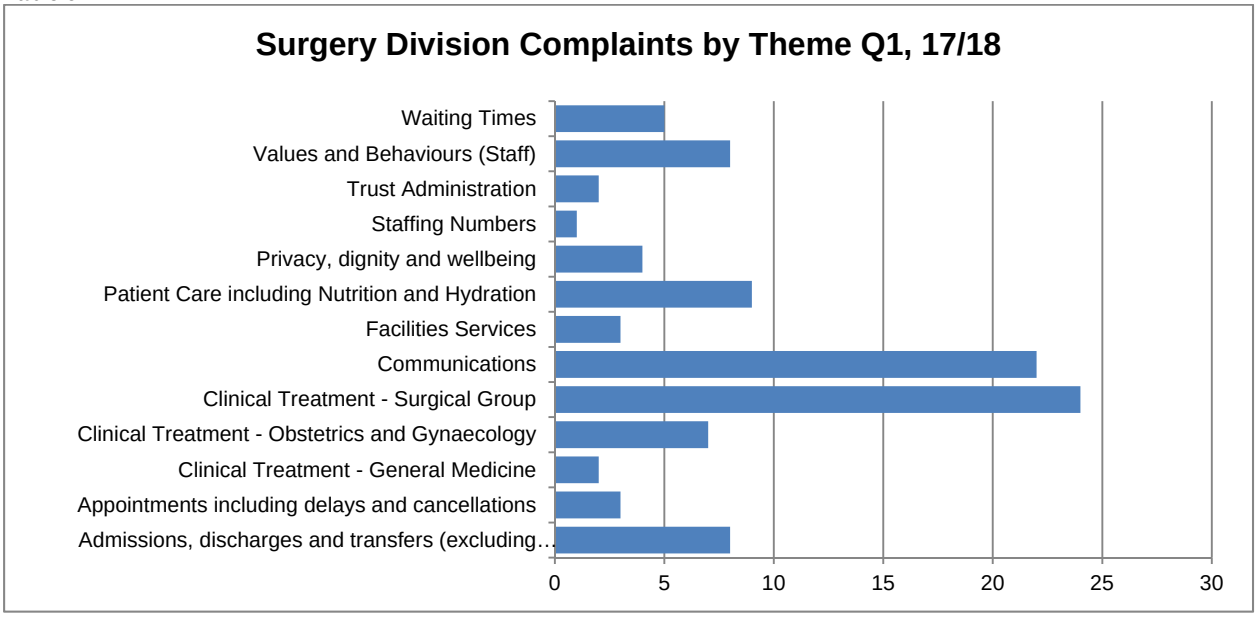


Table 6 details complaints received by subject.

Table 6



The significant themes identified relate to:

- Poor Communication and attitude of staff.
- Delays in ordering tests, treatment and making referrals.
- Delays/cancellations and waiting times.
- Patient care including nutrition and hydration.

Referrals for appointments and tests as an inpatient and upon discharge are taking longer than expected to organise. Patients feel appointments are not being requested properly or discussed between the various specialities. When the surgical team transfer a patient to the medical team (or vice versa) the receiving team

will sometimes decline the transfer resulting in no one taking ownership of the patient. This causes confusion for the patient/family as well as missed or delayed tests/referrals. Patients feel that they have to contact the hospital after discharge to chase up appointments, scans and results. This concern has also been raised under the Medical Division.

Poor communication and information about treatment/care has been raised throughout the trust. Patients feel they are not being given enough time to recover from their procedures or are not receiving the appropriate post-operative care.

Waiting times for appointments and procedures being cancelled has been raised. In some cases patients are concerned that referrals have not been made in a timely manner or paperwork hasn't been completed correctly leading to further delays.

2.3 Other Complaints (Therapy Services now known as the Clinical Services Division)

During Q1, a total of 4 further complaints were received within Therapy Services compared to 2 in Q4, 2016/17 (100% increase). These complaints were in relation to a blood transfusion, staff attitude and patient assistance.

The themes identified related to:

- Lack of Communication
- Unprofessional/unhelpful staff

The complaint regarding a blood transfusion stems back to 1986 when the transfusion was allegedly undertaken. The patient has recently been diagnosed with Hepatitis C which they feel was contracted through the transfusion.

Communication with patients and family's has been raised including staff appearing to be disinterested and not providing basic care.

2.4 Complaint Themes

The overall top 5 themes across the 3 areas over the preceding 2 quarters are summarised as follows:

Quarter 4, 2016/17	Quarter 1, 2017/18
Values and behaviour of Staff	Communication/staff attitude
Communications	Clinical treatment
Patient Care including nutrition/hydration	Patient care including nutrition/hydration
Clinical treatment – General Medicine	Admissions/discharges & transfers
Admissions/discharges & transfers	Delays/ordering tests/scans

2.5 Complaint responses

In Q1, the trust was just below achieving the response target of 90% in accordance with NHS Complaints Regulations. During this reporting period the trust achieved an 89% response rate. This response rate includes all complaints who have agreed to a Local Resolution Meeting (LRM) or an extension due to the complexity of the complaint.

During Q1, 30 responses were provided to complainants from complaints received in previous quarters. All cases during this reporting period were managed within the agreed timeframe. Extensions to the original timeframes were discussed and agreed with the complainants in a timely manner. Six complainants who opened their complaint in Q1 requested an LRM rather than a written response and a further 3 requested an LRM following receipt of a written response

The following provides an overview of Divisional responses during Q1:

- Medical Division provided written responses to 13 formal complaints within the agreed timeframe.
- Surgery Division provided written responses to 15 formal complaints within the agreed timeframe.
- Other (Therapies) provided written responses to 2 formal complaints within the agreed timeframe.

2.6 Complaint Outcomes

Of the 30 complaints responded to during Q1the outcomes were as follows:

- 1 upheld
- 21 partially upheld
- 8 not upheld

For the purpose of clarity the following section provides a working definition of what constitutes an upheld / partially upheld complaint:

'*If any or all of a complaint is well founded then it should be recorded as upheld' NHS Information Centre for Health and Social care 2012.*

Of the 30 complaints responded to during Q1 a total of 4 remain dissatisfied with their initial response and requested:

- Further information/clarification
- LRM

The trust continues to offer LRM's to complainants in response to their complaint. Twenty LRM's took place in Q1 (some of these were from previous quarters) compared to 15 in Q4, 2016/17. The following is a breakdown of LRM's that took place in the respective Divisions:

- Medical Division - 13
- Surgical Division – 7

All LRMs convened include a Divisional representative and a member of the complaints team (and others if required). A CD recording of the meeting is provided to the complainant and a follow up letter is generated to confirm discussions held, findings and subsequent action plans.

2.7 Complaints linked to serious incidents

There were no complaints linked to Serious Incidents (SI) during Q1.

2.8 Actions and Learning

It is essential that the trust continues to learn from complaints and concerns, ensuring service improvements are embedded into every day practice. The following section provides an overview of trust wide service improvements during Q1:

Medical Division:

- All wounds inflicted by glass must by x-rayed on initial presentation to ED.

- To ensure all patients property is documented on transfer to the wards and if valuables are left with the patient then a disclaimer is to be signed

- To ensure patient lockers are emptied and the property checklist is completed before a transfer or discharge. Staff have made magnets to place above the patients bed following transfer so that the staff are aware of patients property (glasses, dentures and hearing aids). C3 have devised a checklist that includes the signing of the disclaimer upon transfer to C3, with a new relatives notice board to highlight the importance of labelling patients property and signing the disclaimer.

- To contact the Next of Kin in the event of a patient falling regardless of time of day/night unless specified. A ‘grab bag’ containing vital products to maintain dignity of patients after a fall are available across the trust to ensure patients are not left unattended. A falls board has been displayed in the staff room. Falls bundle to be reviewed daily. A Collaborative approach and weekly audits to be carried out to monitor changes.

- Lying and standing blood pressure of all patients to be taken upon admission.

- Ward C3 are currently in the process of rotating the Band 6 shift leads onto the night shift to ensure there is visible leadership and a form of escalation during the night. This will ensure the quality and standards on C3 remain high at all times.

- Clearer communication when explaining processes to patient/family in relation to the Root Cause Analysis (RCA) process.

- New learning identified is to be discussed widely across the trust and to be included in newsletters.

- Staff to consider a patient's history and the correct speciality is involved in the patient's care when patients may not suggest there is a cardiac problem. A review of the policy and protocol in ED is to take place in suspected cardiac cases.

- Clerical staff to ensure all appropriate paperwork and procedures are followed on discharge of a patient to ensure further errors are not made.

Surgery Division:

- Clearer and more consistent communication between different departments will be implemented, particularly when referring/transferring a patient and in handover.

- Clearer communication with family's as well as patients. All staff to check with senior medical staff if they are unsure of an answer/diagnosis.

- Senior staff to always meet and speak with family's if arranged and or requested.

- Staff to maintain their professionalism at all times and during any meetings so as not to cause distress or confusion to family's

- Capacity issues do contribute to delays and difficulties which are constantly being reviewed. Consideration to be given to GP's in training with the E-referral team.

Other (Therapy):

- To ensure clear communication between teams on discharge. To review the phone system used and to consider a call waiting system.
- Therapy staff to consider what other assessments may be required if a patient is anxious about going home even if they are mobilising adequately e.g. they have stairs at home.

3. Parliamentary Health Service Ombudsman (PHSO)

The trust received 3 applications from the PHSO during Q1 which are still being considered.

Four cases were completed and reported to the trust by the PHSO as follows:

- One not taken to formal investigation
- Two not upheld
- One partly upheld (Recommendations completed – confirmation sent to complainant/PHSO)

The learning and action plan from the partially upheld complaint has included:

Departmental management guidelines for patients who have swallowed a foreign body have been updated and now state:

- X-ray chest, if likely radio-opaque or patient symptomatic,
- Be aware that not all dentures are radio-opaque,
- Refer the patient to Ear, Nose & Throat or Gastroenterology teams if symptomatic, e.g. has chest or thoracic back pain,
- If patient is asymptomatic perform a swallow test to ensure that this is normal before considering discharge.

In order to ensure compliance, the above is reiterated to all clinical staff in the Emergency Department during regular board/handover rounds.

Details of the case have been shared and discussed at the departmental meeting and the quarterly Governance meeting.

Details of the case have been included in the ED Safety Newsletter

Enclosure 12

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 7th September 2017

TITLE:	Learning from Deaths Policy		
AUTHOR:	Mr R Callender Deputy Medical Director	**PRESENTER:**	Dr P Harrison Medical Director

CORPORATE OBJECTIVE:

SO2: Safe and Caring Service
SO3: Drive service improvements, innovation and transformation

SUMMARY OF KEY ISSUES:

This policy is developed from the existing "Review of Inpatient Deaths" policy in response to the National Guidance on Learning from Deaths (March 2017), and will replace it.

This Policy has been presented to the Trusts Clinical Quality Safety and Patient Experience Committee.

As the Policy mandates new processes and reporting it should be reviewed April 2018.

IMPLICATIONS OF PAPER:

RISK	**Y/ ~~N~~**		**Risk Description:** Failure to learn from deaths
	Risk Register: ~~Y~~/ N		**Risk Score:** 20
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/~~N~~**	**Details:** Safe, Effective, Caring, Responsive, Well-Led.
	Monitor	**Y/N**	**Details:**
	Other	**Y/N**	**Details:** National Quality Board – National Guidance on Learning from Deaths (March 2017)

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
✓	✓	✓	

RECOMMENDATIONS FOR THE BOARD:

The Board to and approve the Policy, confirm the appointment of a Non-executive Director to take oversight of the process and confirm review date.

Review of Inpatient Deaths Policy		
	DOCUMENT TITLE:	Policy on Learning From Deaths
	Name of Originator/Author /Designation & Specialty:	Mr R Callender, Deputy Medical Director
	Director Lead:	Dr P Harrison, Medical Director
	Target Audience:	All Medical Staff
	Version:	1.0
	Date of Final Ratification:	~~July 26th 2016~~
	Name of Ratifying Committee/Group:	Clinical Quality Safety and Patient Experience
	Review Date:	April 2019
	Registration Requirements Outcome Number(s) (CQC)	All outcomes
	Relevant Documents /Legislation/Standards	*National Guidance on Learning from Deaths (March 2017)*
	Linked Procedural documents	*Verification & Certification of Death Policy (Hospital and Community Settings)* *National Guidance on Learning from Deaths (March 2017):* https://improvement.nhs.uk/resources/learning-deaths-nhs/
	The electronic version of this document is the definitive version	

~~CHANGE HISTORY~~

~~Version~~	~~Date~~	~~Reason~~
~~1~~	~~November 2011~~	~~To include development of new database~~
~~2~~	~~June 2013~~	~~Full review~~
~~3~~	~~June 2016~~	~~Full review~~

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

Policy on Learning From Deaths

THE DUDLEY GROUP NHS FOUNDATION TRUST

POLICY ON LEARNING FROM DEATHS

1. INTRODUCTION

This policy is developed from the "policy for review of inpatient deaths" which was introduced in April 2010. That policy had improved the accuracy of information the Trust held for internal assurance, and that submitted to outside organisations, and addressed the development of a new database of inpatient deaths which is automatically populated from OASIS so that a review of every death is recorded. The database is known as the Mortality Tracking System (MTS).

Following the publication of the National Guidance on Learning from Deaths (March 2017): https://improvement.nhs.uk/resources/learning-deaths-nhs/
the policy has been renamed and updated to refocus on learning and to ensure that the Trust's processes meet the standards required.

Significant parts of that guidance discuss the *selection* of cases for review; the Trusts position remains that all deaths should be reviewed and therefore selection of deaths to be reviewed is not part of this policy.

2. STATEMENT OF INTENT

The original processes addressed by the review of inpatient deaths policy remain; they were:

(i) To ensure that circumstances surrounding **all** inpatient deaths are peer reviewed, and thus:

- To learn from deaths
- To provide assurance at Board level of quality of final episodes of care.
- To provide Directorate leadership with information and assurance of quality of care and outcomes within their areas of responsibility
- To have in place a system that can immediately respond to mortality outlier information.

(ii) To ensure that the coding associated with inpatient death is as accurate as possible and to develop clinicians' understanding of the importance of the quality of data for which they are responsible.

2.1 **This policy addresses further issues identified in** *National Guidance on Learning from Deaths**:***

- A requirement that opportunities for learning are always acted upon and that the learning is recorded
- Clear and documented attention to deaths of patients with Learning Disability
- A requirement that bereaved relatives have been invited to voice any remaining concerns, and that any review has taken such concerns into account. (This is in addition to the statutory Duty of Candour)
- Inclusion of deaths in ED into the remit of this policy (these are not admitted patients so have not previously been included in this policy)

- Integration of the review of both paediatric and perinatal deaths into the Trust wide review principle and mortality reporting process

2.2 **Note: None of the above precludes the obligation to report a death via Datix as a serious incident if that is clinically appropriate (eg death potentially avoidable).** Finalised RCAs will be reviewed by the mortality panel (see below) .

2.3 Introduction of this policy will enable comprehensive reporting of learning from death.

3. SCOPE

This policy applies to all clinical staff in The Dudley Group NHS Foundation Trust.

4. DEFINITIONS/ABBREVIATIONS

MTS – Mortality Tracking System

Level 1 review – The first structured review by the department concerned using the MTS questionnaire (Appendix 1)

Level 2 review – The review performed by the Mortality Panel (see below) using "Structured case note review data collection" as advised by the *National Mortality Case Record Review Programme* (See references, Para 10)

Mortality Panel – A group of at least two consultants and a senior nurse that will carry out level 2 review independently from the level 1 reviewing department

LD Nurse - Liaison Nurse Learning Disabilities

5. DUTIES (RESPONSIBILITIES)

Medical Director
The Medical Director and Deputy Medical Director are responsible for keeping under review the functioning of the process addressed by this policy.

Consultant Medical Staff
The Consultant Medical Staff are responsible for adhering to this policy.

Trust Clinical Audit Lead
The Trust Clinical Audit Lead is responsible for coordinating and monitoring the audit process.

Specialty Clinical Audit Leads
The Speciality Clinical Audit Leads are responsible for leading level 1 review of all inpatient deaths in their speciality, ensuring the MTS review tool is submitted and reporting actions on learning to the Medical Director's directorate (See 7. below).

Mortality Panel
The Mortality Panel (panel of consultants) is responsible for level 2 review of adult deaths

- When the level 1 process has produced an alert
- If the patient had been reviewed by the LD Nurse
- When the death has been subject to RCA via Datix

6. PROCESS TO BE FOLLOWED

6.1 Mortality Tracking System

The MTS contains the Consultant recorded as responsible for the patient at the time of death, and will automatically email that Consultant when the notes are available for coding review.

6.2 Clinical Review of Coding of Notes

Clinical review of the coding of notes of deceased patients is required. Incomplete or inaccurate coding can lead to inaccurate submission of data. This review must take place as soon as possible, but in any case **within a month** of the death to allow resubmission of any coding change, and is **the responsibility of the Consultant in charge of the final episode of care.**

The primary code must indicate the MAIN condition actually being treated during the first inpatient episode – this might not be the condition first noted as an initial impression or provisional diagnosis, and it might not be the condition that caused death.

The coders can only code from what has been written in the notes and they cannot interpret results of tests, or speculative entries.

6.3 Process – Consultant Responsible For Last Episode of Care:

The Consultant responsible for the final episode of care or last episode prior to step-down, (as identified by the OASIS PAS System) must liaise with the Clinical Coding Co-ordinator or Clinical Coding Manager to review the clinical record to ensure:-

- Hierarchy of coding is correct, particularly the primary diagnostic code
- Administrative details are correct (admission method, Consultant responsible for the episode/s etc.)
- Diagnostic and procedural coding is accurate
- Co-morbidities, circumstantial codes (e.g. palliative care) are included where appropriate
- The notes indicate what was written on the certificate of death (See Verification and Certification of Death Policy) and whether the coroner was informed.
- Note: The cause of death on the death certificate is not necessarily the same as the condition referred to by the “primary code” on admission.

Additional notes:

- If a Consultant believes they are **not** responsible for the discharging episode (or episode before step-down (as identified by the OASIS PAS System), they must identify the responsible Consultant to the Coding Team.

- Consultants must not delegate this review process to junior members of their team as maximum accuracy is essential

6.4 Subsequent Process For Assurance – Audit Of Final Episode Of Care

Audit leads will be automatically notified of deaths occurring in their departments via the database above. The notification will contain a link to the MTS audit tool. (Appendix 1)

Each Department must undertake a structured review, via the audit tool, of all deaths occurring under the care of their Consultants. The audit lead should aim to undertake the process and complete the audit tool within 6 weeks of the patient death. Both the clinician in charge and the audit lead will be sent a reminder at 6 weeks and subsequently at 8 weeks. A further reminder will be sent at 12 weeks by the Trust Audit Lead. At this point the Head of Service and Deputy Medical Director will also be notified.
The review should take place in a multidisciplinary forum. The audit tool must confirm that Consultants other than the Consultant responsible have contributed to the review. The tool allows free text and comments should be added at the time of the departmental review.

The tool MUST be completed on line and will be stored in the MTS.
The tool is structured to flag any issues of concern that may require further consideration, and such cases will automatically be referred on for a level 2 review by a Trust panel of Consultants. A Primary Care representative is invited to attend this panel meeting.

6.4.1 ALL DEPARTMENTS: *Clear and documented attention to deaths of patients with Learning Disability (LD)*

Patients known to have LD are flagged on OASIS. The LD nurse will automatically be informed. As well as the standard audit, the LD nurse will review the notes and the case will automatically be subject to a Level 2 review

6.4.2 ALL DEPARTMENTS: *Bereaved relatives should have been invited to voice any remaining concerns (This is in addition to the statutory Duty of Candour)*

Even in cases where there is no statutory Duty of Candour, it should be considered and noted at the departmental audit that there is evidence that bereaved relatives have been invited to question or comment on any aspect of care, and that they have been satisfied with the information they have been given. Free text entry should reflect this. Information to this effect will also be given to relatives in the bereavement booklet "*For you in your loss*".
Note:
Good practice will always be that bereaved relatives have the opportunity to discuss concerns with the responsible consultant and this should be the norm.
In cases where a level 2 review occurs the next of kin will be advised of this by letter and given a further opportunity to raise any concerns.

6.4.3 ALL DEPARTMENTS *A requirement that opportunities for learning are always acted upon and that the learning is recorded*

The responses to questions 8 and 9 on the first level audit require a specific response within the text field. In such cases, the departmental audit lead must with the Medical Head of Service, submit a brief note of the learning to the Medical Director. The note need not be a formal action plan, but must include "action by" dates. The note will then be recorded on the MTS

6.4.4 *Inclusion of deaths in ED into the remit of this policy (these are not admitted patients so have not previously been included in this policy)*

Deaths occurring in ED will be subject to a structured review. It is recognised that a modified audit tool may be more helpful/appropriate for ED deaths, and this is being developed in conjunction with the College of Emergency Medicine. Any questionable issues will be referred to second level review panel as with inpatient deaths.

6.4.5 Integration of the review of both paediatric and perinatal deaths into the Trust-wide review principle and mortality reporting process

6.4.5.1 Paediatric Deaths

Level 1 review recorded on MTS. MTS alerts leading to Level 2 review will work as with adult inpatients. In **all** cases bereaved relatives are offered a follow up meeting with Paediatric Consultant.

(Note, safeguarding reviews of all paediatric deaths take place as a matter of course, but by their nature would not necessarily identify problems in clinical treatment.

6.4.5.2 Neonatal deaths – level 1 review recorded on MTS. (included in perinatal meeting) Level 2 review provided by network review. In all cases bereaved relatives are offered a follow up meeting with Paediatric Consultant.

6.4.5.3 Stillbirths – Level 1 review at Departmental MDT (Perinatal Meeting). In all cases bereaved relatives are offered a follow up meeting with obstetric consultant.

Note: A new perinatal mortality review tool is in preparation for national roll out and will be taken up by DGH in due course.

7. Reporting

Reporting on mortality and the learning from deaths will be considered

- at the Mortality Surveillance Group, particularly the detail of actions around learning provided by the departmental audit leads when appropriate
- at CQSPE to provide assurance of the application of this policy and its supporting processes with a focus on the learning and changes / improvements made
- at the appropriate Public Board meetings in a format compliant with all statutory responsibilities.

8. TRAINING/SUPPORT

The Information Department will provide advice and support.

9. PROCESS FOR MONITORING COMPLIANCE

See Table 1.

Table 1 - Compliance monitoring Checklist

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
The Compliance with the review of inpatient deaths policy	Deputy Medical Director	Mortality Tracking System (MTS) Dashboard	6 Monthly	Mortality Report	Trust Audit Leads and Clinical Directors	Mortality Surveillance Group

9. EQUALITY IMPACT ASSESSMENT

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy has been assessed accordingly.

10. REFERENCES

National Guidance on Learning from Deaths:
A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (March 2017)

https://improvement.nhs.uk/resources/learning-deaths-nhs/

Using the structured judgement review method Data collection form (RCP)

https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources

Appendix 1- Mortality Tracking System Audit Tool

Question (Audit Form v4)
1) Is it clear from the notes that a plan of care was made on admission by a doctor of sufficient seniority?
2) Was there a delay in any investigation, procedure, operation or referral, or failure to respond to a result or report which affected outcome?
3) Were there any identifiable actions taken that could have contributed to death?
4) In your judgement, is there some evidence that the patients death was avoidable?
4.1) Has it been reported on Datix?
4.2) Is the RCA available?
5) In the opinion of the review team, was there a perceived deficiency of care from another department which may have contributed to death?
5.1) Is evidence available that it has been reviewed with the department involved?
6) Was the patient admitted <24hrs before death from a care home? (Please note care home in free text)
7) Was the patients' ward location appropriate?
8) Have any/all learning points from the review of this death been shared throughout your department?
9) Are there any learning points which should be shared more widely?
9.1) Has your department taken action to share these learning points more widely?
10) Was it recognised that the patient would die during this admission?
10.1) Was this documented?
10.2) Were there documented discussions with patient and family?
10.3) Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care?

Enclosure 13

Paper for submission to the Trust Board (September 2017)

TITLE:	**Dudley Group NHS Trust Winter Plan 2017/18**		
AUTHOR:	**Johanne Newens, Director of Operations, Medicine and Integrated Care**	**PRESENTER**	**Ned Hobbs Director of Operations Surgery** **Anne-Marie Williams Director of operations Clinical Support**

CORPORATE OBJECTIVE

S01 **Deliver a great patient experience**

S02 **Safe and Caring Services**

SUMMARY OF KEY ISSUES:

It is recognised and anticipated that patient flow pressures through the Hospital and the Emergency Department during winter months may cause delays for patients care. The aim of the Dudley Group winter plan 2017/18 therefore is to have in place actions that mitigate against these delays underpinned by the following objectives:

- Ensure safe effective care throughout services during the winter period
- Minimise delays to patient care by ensuring responsive services
- Have in place a streamlined model of assessment and triage to ensure patients get the right place of care as soon as possible
- Ensure that ED in particular is resilient and can function effectively on a 24 hour basis.

This plan also takes into account the winter planning guidance of 2017/18 which has specific requirement for all Health and Social care partners within the health economy. This plan describes the actions that Dudley Group will deliver to contribute to the objectives within this guidance, namely:

- Ensuring there is enough capacity to meet the demands of winter (target of maximum 92% bed occupancy throughout the period)
- Reforming and redesigning the wider urgent and emergency care system (having in place Urgent treatment centres)

In order to identify the specific actions to deliver the above objectives a wide range of information has been considered in respect of activity within Dudley Group over previous winters and

previous months.

- Analysis has been undertaken in relation:
- Patterns of presenting illness
- Length of stay for specific conditions
- Attendance peaks
- Bed occupancy and actions and mitigate

This paper describes this analysis and in section 4 the associated actions planned to mitigate the impact of the findings of this in the forthcoming winter.

A detailed the operational plan for each division and command and control structure has been prepared and with be presented to the Board meeting.

A costed analysis of full winter implications will be completed.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: impact on delivery of national targets**
	Risk Register: **Y**		**Risk Score: relevant targets have been included on the divisional risk register**
COMPLIANCE **and/or** **LEGAL REQUIREMENTS**	**CQC**	**N**	**Details:**
	Monitor	**N**	**Details:**
	Other	**y**	**Details: NHS England / NHs I standards and performance metrics**

Decision	**Approval**	**Discussion**	**Other**
		Y	

RECOMMENDATIONS FOR THE Executive team:

To note the contents of the paper.

Dudley Group NHS Trust

WINTER RESILIANCE PLAN

2017/18

Contents

.0 EXECUTIVE SUMMARY

This paper has been produced to describe how the Trust is proposing to respond to increased surges and/or continued periods of higher than usual service demands during the winter period and to:

- Ensure safe effective care throughout services during the winter period
- Minimise delays to patient care by ensuring responsive services
- Have in place a streamlined model of assessment and triage to ensure patients get the right place of care as soon as possible
- Ensure that ED in particular is resilient and can function effectively on a 24 hour basis.

The plan also takes into account the elements of the **NHS England winter planning guidance 2017/18 t**hat DGFT play a significant role in delivering:

- Ensuring there is enough capacity to meet the demands of winter (target of less than 92% bed occupancy throughout the period)
- Reducing DTOCs
- Reduce variations in practice
- Primary care streaming
- Reforming and redesigning the wider urgent and emergency care system
- Urgent treatment centres

Some high level evaluation of the past three years indicates the following:

- Type 1 ED attendances are have little variation in numbers without significant winter spikes
- Type 3 attendances (majors) have shown a gradual rise throughout the year
- Admission patterns during Q3 have shown a consistent increase year on year from 10222 in (2014/15) to in 2016/17 (11383).
- Bed Occupancy remained at a higher level for longer period of time in Q4 2016/07 compared to the previous 2 financial years.
- The longer lengths of stay for the winter period is seen older care and general medicine patients.

In line with the guidance and the analysis a number of solutions have been identified to ensure the Trust is able to respond to these predicted surges in demand, the detailed information in the main body of the report analyses some of the specifics and patterns in this demand.

2.0 PURPOSE

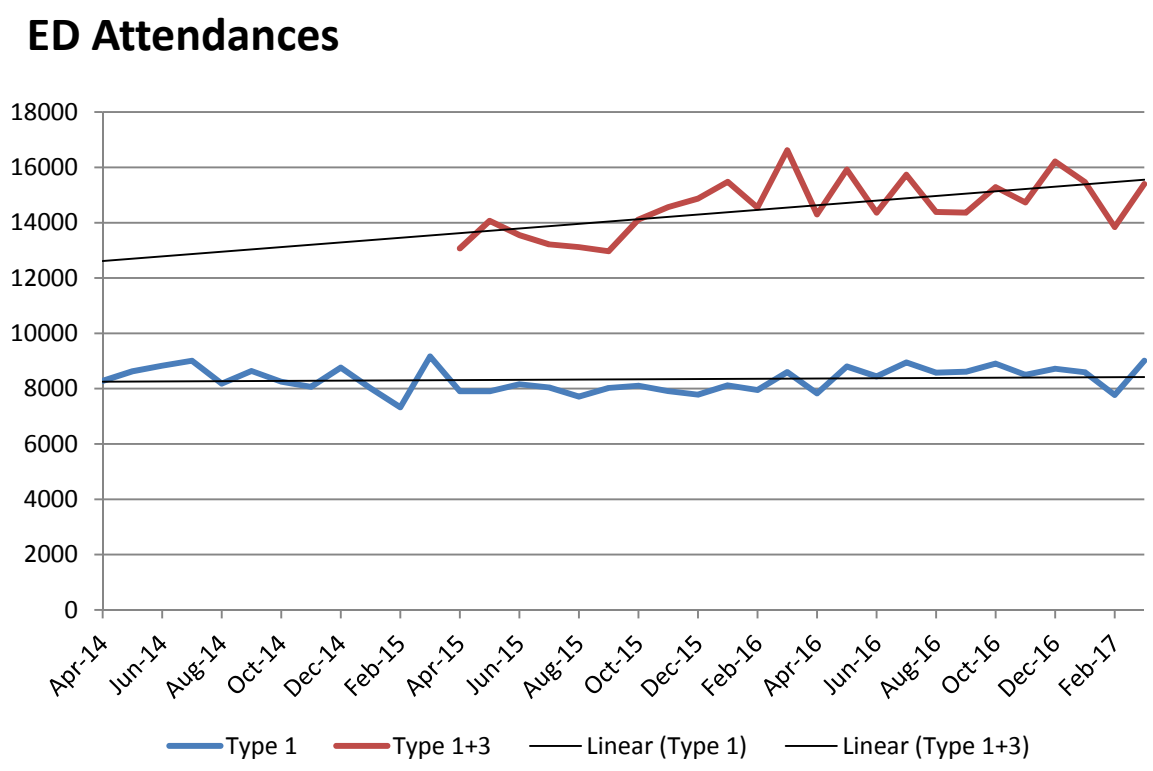
The purpose of the winter plan is to ensure the Trust is prepared to respond to increased needs demands during the winter period. For the benefit of this winter plan the period is defined as October 17 to March 18, this may be subject to extension if pressures emerge outside of this period.

3.0 EVALUATION OF 14/15, 15/16 AND 16/17 WINTER PERIODS

This section shows some of the detailed analysis that has been done and some of the key information that has been considered in formulating the plan. The previous 3 winters have been analysed to:

- Enable robust and effective modelling of winter demand and required capacity.
- Identify any further actions that will increase the resilience of the organisation to growth in demand over winter.

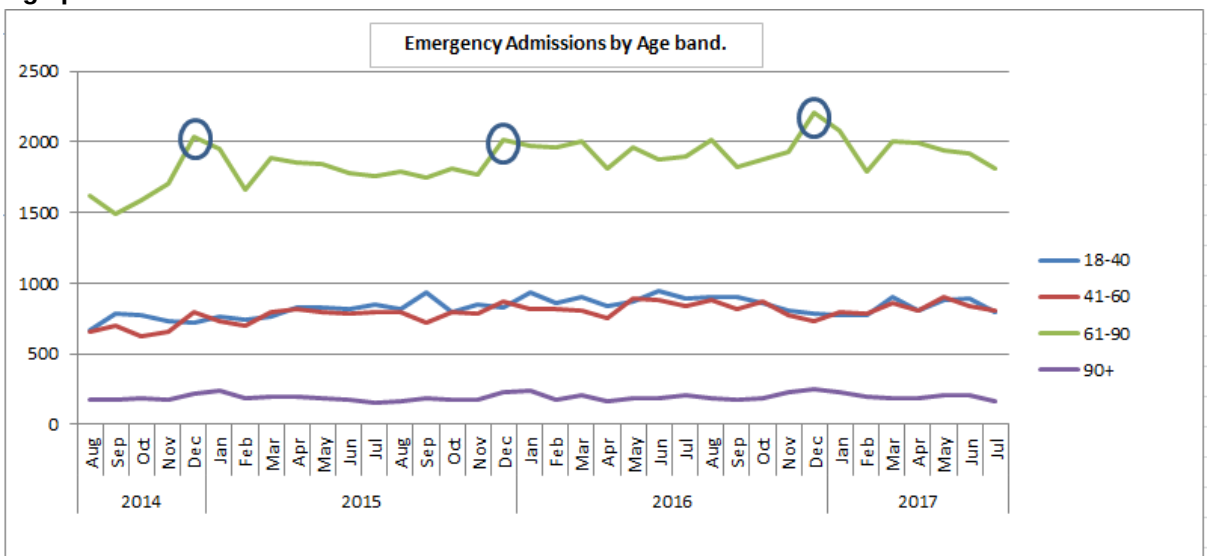
3.1 ED ATTENDANCES



Type 1 attendances saw a drop when UCC was moved onsite (April 15), but has continued to rise and is now on a par with the number of attendances seen prior to April 15.

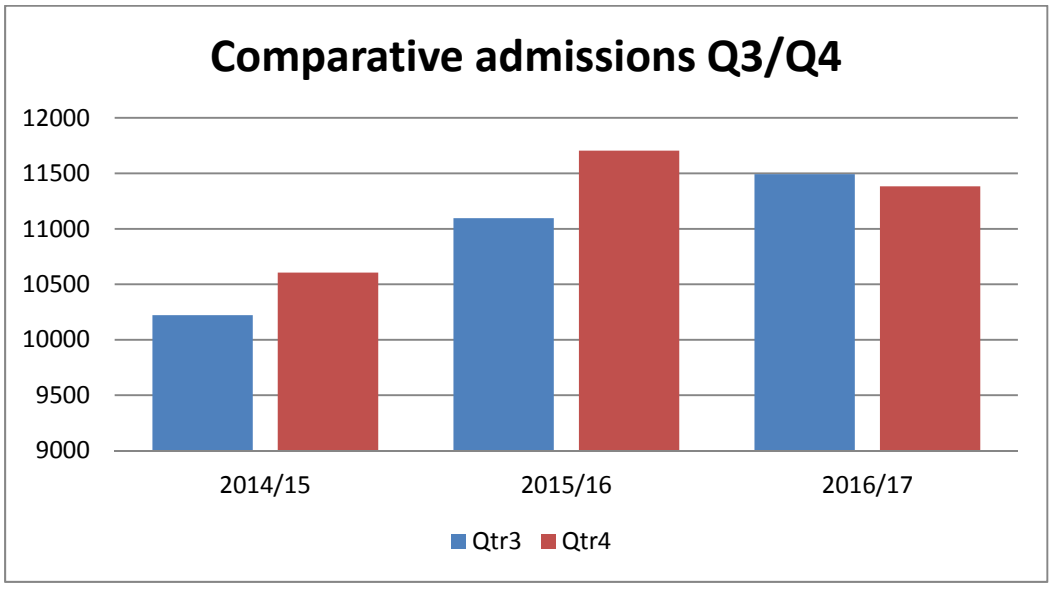
3.2 ADMISSIONS

Age patterns



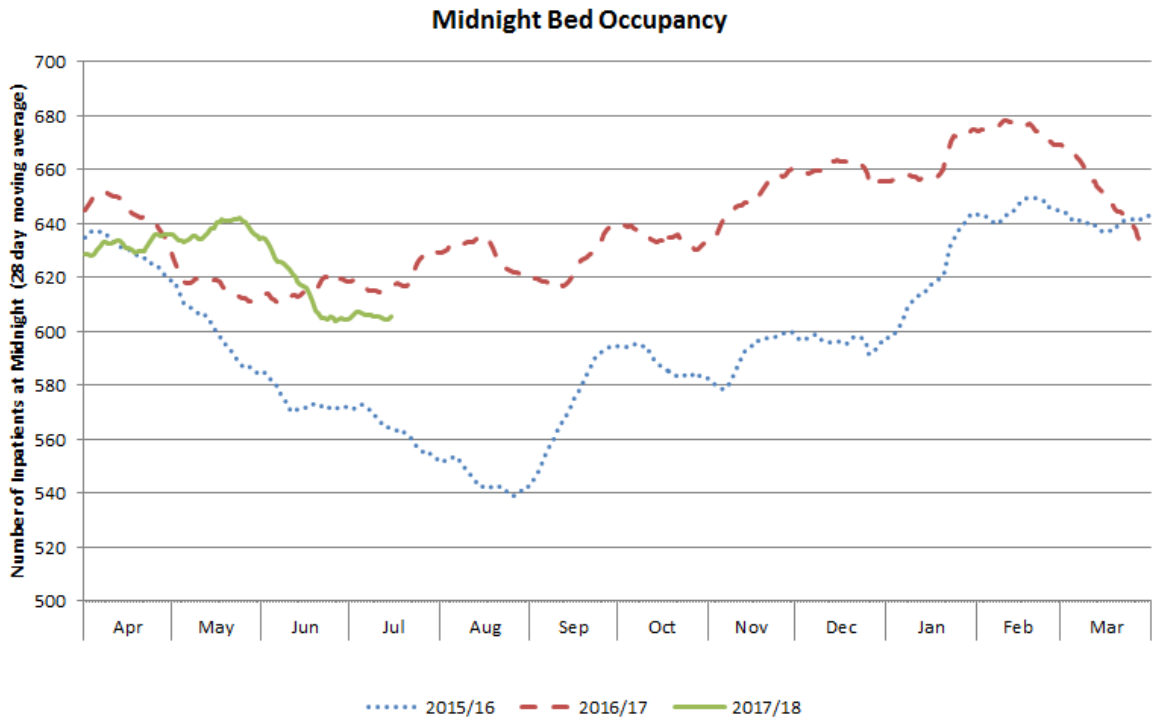
There are slight winter peaks associted with admissions in the 61-90 age group.

Q3/Q4 Admission Patterns



Admission patterns Q3 / Q4. Q3 has shown a consistent increase year on year from 10222 (2014/15) to 11493 (2016/17). Q4 showed a significant increase between 2014/15 (10606) to 2015/16 (11705), but dropped back slightly in 2016/17 (11383).

Bed Occupancy



Bed Occupancy remained at a higher level for longer in Q4 2016/07 compared to the previous 2 financial years. The target to us achieving efficient and effective patient flow is less than 92%. This graph demonstrates that our bed occupancy was above this threshold from November through till mid-March last year, and from January to March 15/16 varying from 96% to 100%.

Admissions by speciality. Analysis over the last 2 winters demonstrates an increase in the number of acute medicine patients, with some spikes in respiratory and geriatric patients. However the key element of these trends / analysis is the length of stay associated with different specialities.

3.3 LENGTH OF STAY AND ACUITY

1. General analysis of Average Spell LoS by specialty

   There is no consistent winter peak associated with any specialties across the 3 years. General Medicine had a peak in the 16/17 winter as did Stroke Medicine. Geriatric Medicine had a peak in 16/17 in the run up to winter.

2. Differential in length of stay between under 60s and over 60s.

There is a significant diferential between the two age groups as can be seen above i.e patient admitted aged over 60 have a up to 4 days LOS more than those under 60.

So to summarise in order to achieve 92% bed occupancy, fewer acute medicine (these are higher volume admissions during winter) and fewer geriatric patients

need to be admitted (these have a higher average LOS) and those patients under any speciality who are 60 years plus need to have a reduced LOS.

3.4 Delayed Transfers of Care. (DTOCs)

The table below shows that each year there has been a rise in the number of DTOCS, which result in lost bed capacity to the Trust. With the predicted rise in ambulance activity and type 3 attendances and potential for increased admissions for over 60s these lost bed days pose a significant risk to the ability of the Trust to maintain 92% bed occupancy. The Better Care Fund monies available to the health economy offer a significant opportunity to address this risk. The better care fund monies have been allocated on a basis of saving DGFT 5200 bed days per year, this equates to approximately 23 beds. The Local Authority are in the process of

DGFT

	Nov-14	Dec-14	Jan-15	Feb-15	Nov-15	Dec-15	Jan-16	Feb-16	Nov-16	Dec-16	Jan-17	Feb-17
Delayed Days	986	913	778	947	1046	1246	871	892	1460	1322	1350	1746
Days in month	30	31	31	28	30	31	31	29	30	31	31	28
Delays per day	32.87	29.45	25.10	33.82	34.87	40.19	28.10	30.76	48.67	42.65	43.55	62.36
Occupied Bed Days	690	690	673	673	634	634	667	667	685	685	695	695
Delays as a % of Occupied Days	4.76%	4.27%	3.73%	5.03%	5.50%	6.34%	4.21%	4.61%	7.10%	6.23%	6.27%	8.97%

recruiting a number of additional social care staff to support admission avoidance and also “front of house” team to enable prompter turnaround of patients presenting at ED. The CCG are also planning to commission 50 additional community beds which will be phased in from September 2017. This will enable patients who would normally receive social care or continuing health care assessments in an acute bed to be transferred to a community bed to receive this assessment.

3.5 Predicted Triggers

Dudley group use a trigger prediction model to anticipate levels of demand that are over the normal levels of activity that the Trust can accommodate with relative ease. These triggers (1 being lowest 5 being highest) have been calculated based on the previous sections analysis and the trigger days for last winter. This is a useful guide to anticipate demand / impact. What this does demonstrate is that the greatest period of pressure is likely to be from the 30th December 2017 to the 6th January 2018. This offers the Trust very little opportunity to recover from pressure and adverse effect on business / care.

3.6 BED REQUIREMENTS TO MANAGE WINTER DEMAND

The current bed availability within Medicine & Integrated Care is 411 beds with a further 17 flex beds which were utilised last winter.

When we look at the actual number of patients that were admitted in medicine against this bed availability shows that for the previous 12 months assuming we aim to be at an occupancy rate of no more than 92%, the number of patients almost always exceed the number of beds available. Thus the way the impact on the Trust in relation to lack of medicine beds would be to do any or all of the following

- run at occupancy rates greater than 92%, this impacts on quality and potentially safety
- Open more beds in flex areas (over and above the planned winter capacity). It is important to note that these flex areas are not designed for beds and are typically day case areas.
- Outlie patients to non-medicine wards such as surgical beds
- have significant trolley waits in ED

None of the above bullet points are conducive to effective patient care or delivery of a good patient experience. These options are “reactive” and need to be avoided in order to ensure that the Trust, the health economy is resilient for winter.

4.0 PROPOSED INITIATIVES

The actions to be implemented over the winter period within Dudley Group are designed to take into account trends and patterns of recent years and recent months and are themed around this winter’s NHS England guidance:

1. Ensuring there is enough capacity to meet the demands of winter (target of less than 92% bed occupancy throughout the period) by consistent use of Red to Green to reduce internal delays, transferring patients to community facilities (via the Better Care Fund opportunities) and if absolutely necessary utilising ward B6, currently empty (17 beds).

4.1 URGENT CARE

- Increased nurse cover in ambulance triage during peak times (when triggers indicate ambulance peaks)
- Increased ANP cover within minors out of hours to release Dr time to majors
- Increased consultant cover at weekends and evenings
- The opening of the new UCC triage process will enable more patients to be directed to UCC rather than A&E
- Use of AMRAT – more immediate assessment of ambulance patients from ambulatory care team

4.2 MEDICINE

- Increased ward rounds at Weekends and criteria lead discharge processes in place.
- Reduction in clinics first week of new year to support ward based activities
- An assessment of bed utilisation review with subsequent actions to deliver best practice guidelines for discharge.
- Red to Green and SAFER discharge bundle use throughout the period
- Extra contingency area of B6 (17 beds) for general medicine / elderly care should this be required
- Extra contingency area of A4 (8 beds) for acute medicine should this be required
- Trial of acute physician triage in ED from beginning of September
- Increase in EAU bed base upon move to A1/ A3 (relocation of EAU)

4.3 FRAILTY ASSESSMENT UNIT

- In reach from community to support discharge
- Increased consultant cover
- Increase in bed base upon move to A1 / A3

4.4 SURGERY / ORTHOPAEDICS

- Increase in Same Day Discharge of Emergency Patients:
- Improve Day case Rates
- Theatres, including pre-op optimisation of elective patients

4.5 PAEDIATRICS

- Improved paediatric consultant cover, staff PAU 24 hours along with identified other paediatric contingency area during peak times.
- Extra consultant cover

4.6 CLINICAL SUPPORT SERVICE

- One scanner to remain ‘not booked’ Monday to Friday to accommodate in-patients and urgent scans
- Increase radiologists on site weekends and bank holidays
- The improved efficiency from the introduction of new analytical systems provide the department and the Trust with the capability to cope with any unexpected increases or decreases in sample numbers as a result of winter pressures

4.7 PHARMACY

- Longer opening hours at weekends and bank holidays (from 5 hours to 7.5 hours)

- Enhancements to Medidose service to support discharge on weekends

4.8 COMMUNITY

- Community Hub referral pathways will be open to Ambulance Service and Local Authority Care Teams from November 2017 to promote hospital avoidance
- Hydration Pathway into Community IV Team to support early hospital discharges live from November 2017
- Assertive Case Managers to in-reach into Russells Hall each day and reporting to Capacity hub and Frailty Assessment Unit to support early discharge

2. Reforming and redesigning the wider urgent and emergency care system

Urgent treatment centres – the new joint UCC and ED triage and assessment area will open in November 2017 and will enable more patients to be streamed / triaged direct to the UCC rather that minors in ED.

5.0 ON SITE MANAGEMENT (command and control)

Throughout winter rotas will be reviewed to ensure improved out of hours cover from senior managers and nurses. For the month of January this will be extended to ensure that weekends have a particular focus.

Multi- agency conference calls will happen daily at an operational level to ensure delays are managers and at weekends and during January and “gold” call will be held with directorates of partner organisations and out of area local authorities to enable prompt escalation and support to be mobilised.

6.0 RECOMMENDATIONS

The executive team are asked to:

- Note and feedback on the supporting analysis and high level proposals.

The Dudley Group
NHS Foundation Trust

Enclosure 14

Paper for submission to the Board of Directors
On 7 September 2017

TITLE	Finance and Performance Committee Exception Report		
AUTHOR	Paul Taylor Director of Finance and Information	**PRESENTER**	J Fellows Non-Executive Director
CORPORATE OBJECTIVE: S06 Plan for a viable future			
SUMMARY OF KEY ISSUES: Summary reports from the Finance and Performance Committee meeting held on 31 August 2017.			

RISKS	**Risk Register**	**Risk Score Y**	**Details:** Risk to achievement of the overall financial target for the year
COMPLIANCE	**CQC**	**Y**	**Details:** CQC report 2014 now received, and Trust assessed as "Requires Improvement" in a small number of areas.
	NHSLA	**N**	
	NHSI	**Y**	**Details:** Achievement of all Terms of Authorisation
	Other	**Y**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of the report.

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**31 August 2017**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- Plans are in place to eradicate the Paediatric Follow Up Outpatient backlog in accordance with the agreed timetable
- The Trust's Cost Improvement Programme 2017-18 of £12.5m is currently on track to achieve at this level
- The achievement of the objectives in the Trust Plan 2017-18 shows a marked improvement from Q1 to forecast Q2
- The Month 4 Income and Expenditure position is £79,000 (including consolidation of DCSL) behind plan on a cumulative basis and additional saving schemes have been targeted to achieve the year-end control total surplus (in order to receive the full Sustainability and Transformation Funding).
- The Trust's liquidity position at the end of July 2017 was above planned levels
- Procurement KPI's are on target for Q1 of 2017-18.
- The deficiency points position for the PFI contract for July 2017 were discussed

Decisions Made / Items Approved

Actions to come back to Committee

- A separate meeting of the Committee to be held to review the month 6 financial position and the additional saving schemes that were identified as part of the report presented to the Committee. This will inform the forecast position the Trust will report to Board and NHSI during Q3.

Performance Issues to be referred into Executive Performance Management Process

- The falling A&E 4 hour target and the associated improvement programme.
- Medical agency costs and need for greater control.

Areas of Risk to be escalated onto the Corporate or Divisional Risk Register

- It was agreed to split out COR079 into separate performance risks rather than have one risk for a number of targets.

Items referred to the Board for decision or action

- The current financial position at month 4 and the risks to the current forecast.

Enclosure 15

The Dudley Group NHS Foundation Trust

Trust Board 7th September

TITLE:	**Key Performance Targets Report for Month 04 (Jul) 2017/18**		
AUTHOR:	**Andy Troth** **Head of Informatics**	**PRESENTER**	**Paul Bytheway** **Chief Operating Officer**

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO4: Be the place people choose to work
SO5: Make the best use of what we have

SUMMARY OF KEY ISSUES:

A&E target

Was not achieved with performance in July of 89.1**%** for combined Type 1 and Type 3 down from 93.5% in June. The Trust's ED department was 82.7% down from 90.0%. An improvement programme has commenced the deterioration this month is associated with an increase in breaches associated with ED along with EAU breaches. CEO / COO are holding a series of urgent meetings to improve performance.

Cancer 62 day

The **provisional** performance figures for Cancer 62 day wait for July is 83.7% as at 29th August, this is in line with the agreed trajectory and we are on track to deliver the standard in September as per the national guidance. Q1 did not achieve the target at 80.4%. The Weekly Cancer Performance meeting continues to meet and a Cancer Sustainability Plan has been formulated that reviews our process and delivery systems against the best practise guidance. The Cancer Intensive Support team are undertaking a review in September 2017, to support sustained cacner performance.

Referral to Treatment (18 week)

Incomplete pathways was achieved in July with a performance of 94.39% against a target of 92%, although performance 2 specialities fell below the expected performance

Urology(89.78%) – slightly down from last month
Ophthalmology (85.2%) – slightly down from last month

The non-admitted measure of 95% was not achieved based on a provisional figure of 92.9%. The admitted measure was above its target of 90% at a provisional figure of 90.8%.

DM01 Diagnostic Performance

Was not achieved for July with a performance of 97.8% against a national target of 99%. The internal improvement trajectory has been exceeded in month (original trajectory was 97.1%) but formal delivery of the target is not expected until September, we remain on track to deliver this.

C.Diff cases

4 in month.

Mixed sex accommodation

0 breaches in month.

Never Events

There were 0 never events recorded in month.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description**: High levels of activity could impact on the delivery of KPIs – particularly the emergency access target and RTT. The latter would be impacted by increased levels of outliers resulting in cancelled operations**.**
	Risk Register: Y		**Risk Score: 20 (COR 079)**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details: (*Please select from the list on the reverse of sheet)***
	Monitor	**Y**	**Details:** A sustained reduction in performance could result in the Trust being found in breach of licence
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	**Approval**	**Discussion**	**Other**
		x	

RECOMMENDATIONS FOR THE COMMITTEE

To note the contents of the report and approve

Report of Chief Operating Officer
to the Finance and Performance Committee

Key Performance Targets Report for Month 04 (Jul) 2017/18

1. Introduction

This paper aims to present to the Committee performance against key areas, highlighting good performance and identifying areas of exception, together with the actions in place to address them.

2. Key Issues

a) A&E 4 hour wait – Page 4

The combined Trust and UCC performance was below target in July 2017 at **89.11**%. Whilst, the Trust only (Type 1) performance was **82.74**%

The split between the type 1 and 3 activity for July was:

	Attendances	Breaches	Performance
A&E Dept. Type 1	9056	1563	**82.74**%
UCC Type 3	5297	0	**100.00%**

We saw a worse position within the Emergency Access Standard for July, there were more ED breaches within July associated with 100 more ambulance deliveries than June, with a sharp rise in majors patients

The Trust has taken action to tackle these issues.

b) Cancer Waits

The Committee is reminded that due to the time required to validate individual pathways, the cancer waiting times in this report are **provisional only**. In addition, the reporting of patients breaching 104 days is provided 1 month retrospectively.

Cancer – 62 Day from Urgent GP Referral to Treatment performed below target for July at 83.7% as at 29th August. Q1 was not achieved at 80.4%.

Cancer - 104 days - Number of people who have breached beyond 104 days (June)

No. of Patients treated on or over 104 days (DGFT)	1
No. of Patients treated on or over 104 days (Tertiary Centre)	3
No. of Patients treated on or over 104 days (Combined)	4

c) Referral To Treatment (RTT)

NOTE: Bringing the extraction of data forward in month to achieve reporting deadlines means that the figures for the month are **provisional**.

The performance of the key target RTT Incomplete Waiting Time indicator remained strong, with performance of 94.39% in month against a target of 92%, a slight decrease in performance from 95% in June. Neurology returned to achieving the target at 93.26%. Urology did not meet the target in month at 89.78%, down slightly from 90.98% in previous month. Ophthalmology is at 85.2%, slightly down.

The admitted pathways figure achieved target at 90.8% (90%), an increase on the previous month. Non-admitted was at 92.9% below its target of 95%, a decrease on the previous month.

There were no 52-week Non-admitted Waiting Time breaches in month.

d) Diagnostic waits

The diagnostic wait target was not achieved in July with a performance of 97.80% (against a trajectory of 97.1%). This was an Improvement from the June position of 96.9%. The number of patients waiting over 6 weeks has fallen again from the previous month, 231 to 158.

Of the 158, Non-obstetric Ultrasound accounted for 102, MRI 48, and CT 2. Dexa Scan accounted for another 4.

A diagnostic trajectory plan has been put in place that supports month on month improved performance, returning to delivery by September 2017. The trajectory is outlined below

	Jul Actual	Aug Forecast	Sep Forecast	Oct Forecast
MRI Breaches	48	35	28	25
MRI Extra Capacity	6	6	6	
CT Breaches	2	10	5	5
CT Extra Capacity	180	180	180	
US Breaches	102	70	35	30
US Extra Capacity	120	345	345	
Others	6	5	5	5
Total Breaches	158	120	73	65
Total Activity (denominator)	7500	7500	7500	7500
DM01 %	97.80%	98.40%	99.02%	99.13%

e) HCAI

Total No. of C. Diff cases identified after 48hrs for July was 4. (9ytd.)

	July	YTD
Total No. of cases due to lapses in care	N/A	4
Total No. of cases NOT due to lapses in care	N/A	N/A
No. of cases currently under review	5	N/A
Total No. of cases ytd.	N/A	9

There were 0 post 48 hour MRSA cases reported in month.

f) Never Events

There were 0 reported never events in month.

g) Mixed Sex Sleeping Accommodation Breaches (MSA)

There were 0 breaches reported in month.

h) VTE Assessment On Admission: Indicator

The indicator did not achieve the target in July with **provisional** performance at 94.29% against a target of 95%. This is an increase on June's performance of 93.5%. The committee will note the roll out programme that was rolled out in Q1.

i) Stroke Medicine - Suspected High Risk TIA Assessed and Treated < 24hrs from Presentation

This KPI was met in month at 100% against a local target of 85% (the performance dashboard is produced prior to completed review hence the different number) For 2017/18 the guidance and requirements for seeing TIAs are changing, with all TIAs to be seen within 24hrs (except where the event is over 7 days prior to referral), but requirements for further assessment and treatment vary. The Indicator will be retitled to TIAs Seen within 24hrs.

j) Stroke Medicine – Swallowing Screen

This KPI was met in month with a **provisional** figure for July 75% (36/48) against a local target of 75%. It is to be noted that after validation the June final figure rose from 77.8% to 82.2%.

k) Finance

The overall financial performance to July was fractionally lower than plan by £0.164m. Consolidation of Dudley Clinical Services Ltd into the Trust position reduces the cumulative deficit to £0.107m. The Trust therefore remains on course to achieve the financial component of the STF for Q2. However, there is a significant risk regarding the performance against the ED 4 hour target and it seems likely that the Trust will lose 15% (£0.257m). Day Case and A&E attendances remain above plan and 16/17. Emergency activity and Births are in line with plan and 16/17 but Elective and Outpatient are falling some way short. Following a concerted effort to clear the backlog of District Nursing activity, the Community activity is now over-performing against plan. Agency spend increased in July and further work is required to deliver a downward trajectory (particularly Medical staff). Clinical Support Worker agency costs have reduced dramatically. Bank spend has increased in July but this is in-keeping with the time of the year and WLI payments remain comparatively high. The unmitigated forecast position shows an outturn that is £4.561m over plan and thus represents a significant risk. Mitigating actions are being developed to determine whether this estimated position can be recovered/reversed although there remain significant risks regarding income and the CCG's ability to pay. At some point, the Trust will need to decide whether to invoke the NHSI protocol for in-year forecast changes
Liquidity is above plan at month 4 with a rating of 15.2 against a plan of 10.4. This is as a result of the stronger net current assets position compared to plan. Capital service cover is slightly lower than plan as a result of the very small I&E adverse variance compared to plan the Trust has reported at month 4.

l) Workforce

Appraisals:

July has seen a small increase in the percentage of appraisals undertaken, from 82.9% in June to 83.9%. Clinical Support Division are red at 65.03% (below 80%). Corporate/Management ,Surgery and Medicine and Integrated Care are amber at 86.8%, 88.6% and 85.4% respectively (>80% <90%).

Mandatory Training:

Mandatory Training has risen slightly from 84.6% in June to 85.07% in July. The Director of HR is working with respective Divisions based on the feedback from a series of forums that were held to identify issues within the mandatory training system. The Clinical Support Division is red at 79.35%. Within this division all are red except Pharmacy which is achieving target at 91.63%.

Only the Urgent Care directorate in the other divisions are red with 73.13% The Chief Executive has signalled that for the year of 2017/18 that the Trust's targets need to be met.

Sickness:

Sickness rate overall has risen from 3.9% in June to 4.0% in July. Medicine & Integrated Care are red with 4.38% and Surgery division red at 4.40%. Within the Medicine & Integrated Care division, Integrated care, Nursing Medicine directorate is red with 5.8%. Within the Surgery division; Nursing surgery, Theatres & Critical Care, and Surgery Division Management directorates are red with 6.44%, 4.14% and 7.24% respectively.

M) Single Oversight Framework (SOF)

The Trust's self-assessment against NHSI's single oversight framework is included at Appendix 1 to this report. We are awaiting the formal NHSI assessment but we consider we would remain within segment 2.

N) Electronic Communication with Primary Care

This indicator remains below target (90%) at 79.4% further work is being introduced and this has continued to see an increase in August 2017 A Contract Notice has been issued by the CCG.

3. Recommendation

Finance and Performance Committee is asked to: Note the contents of the report and approve.

Paul Bytheway
Chief Operating Officer

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board Committee on 7th September 2017

TITLE:	Transformation and Cost Improvement Programme (CIP) Summary Report		
AUTHOR:	Amanda Gaston, Head of Service Improvement and Programme Management	**PRESENTER**	Paul Taylor, Director of Finance and Information

CORPORATE OBJECTIVE:
SO3: Drive service improvements, innovation and transformation
SO5: Make the best use of what we have
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

The Trust has an overall Cost Improvement Programme (CIP) target of £12.5m in 2017/18.

To support this, the Trust has identified 41 of 79 schemes currently on the work programme contribute to the £12.5m identified, and 3% of the CIP has currently been identified as non recurrent savings.

Based on the Month 4 position, the Trust has achieved £2,653k against the year to date (YTD) plan of £2,537k**,** with a forecast by the end of the year to deliver £12.7m.

Of the 41 projects due to deliver savings in 2017/18, 37 Project Initiation Documents (PIDs) have been approved by the Transformation Executive Committee (TEC).

31 Quality Impact Assessments (QIAs) have now been approved by the panel with 4 pipeline scheme QIAs scheduled for panel on 16th August.

Transformation Executive Committee (TEC) met on 17th August to discuss:

- Review overall CIP delivery status and progress for 2017/18 to date.
- Review risks to delivery and agree mitigation plans.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details: (*Please select from the list on the reverse of sheet)***
	Monitor	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE: *(Please tick or enter Y/N below)*

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE COMMITTEE:

Note delivery of CIP to date and the end of year forecast.

CORPORATE OBJECTIVES : ***(Please select for inclusion on front sheet)***
SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO3: Drive service improvements, innovation and transformation
SO4: Be the place people choose to work
SO5: Make the best use of what we have
SO6: Deliver a viable future

CARE QUALITY COMMISSION CQC) : ***(Please select for inclusion on front sheet)***	
Care Domain	**Description**
SAFE	**Are patients protected from abuse and avoidable harm**
EFFECTIVE	**Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence**
CARING	**Staff involve and treat people with compassion, kindness, dignity and respect**
RESPONSIVE	**Services are organised so that they meet people's needs**
WELL LED	**The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture**

The Dudley Group NHS
NHS Foundation Trust

Transformation Executive Committee

Programme Management Office

Summary Report

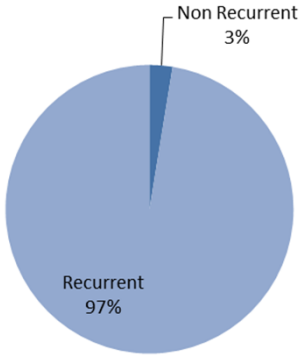
7th September 2017

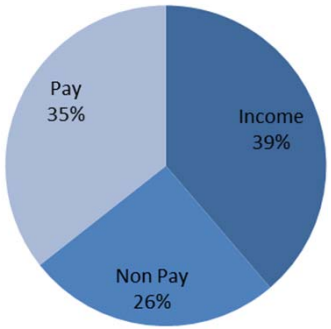
Executive Summary – 2017/18

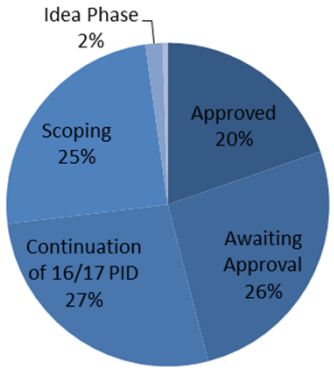
The Trust has an overall Cost Improvement Programme (CIP) target of £12.5m in 2017/18. To support this, the Trust has identified 41 of 79 schemes currently on the work programme contribute to the £12.5m identified, and 3% of the CIP has currently been identified as non recurrent savings.

A summary of CIP performance as at Month 4 is provided below (with supporting detail overleaf):

	Full Year (FY)			YTD Performance against identified Plans			Y/E Forecast of identified Plans	
CIP Project Plans	FY Target	FY Identified	Variance against FY Target	YTD Plan (from identified schemes)	YTD Actual	YTD Variance (against identified schemes)	FYE forecast of identified schemes	FYE Variance of identified schemes
TOTAL	£12.5m	£12.6m	£133k	£2,537k	£2,653k	£116k	£12,711k	£77k







Based on the Month 4 position, the Trust has achieved £2,653k against the year to date (YTD) plan of £2,537k, with a forecast by the end of the year to deliver £12.7m.

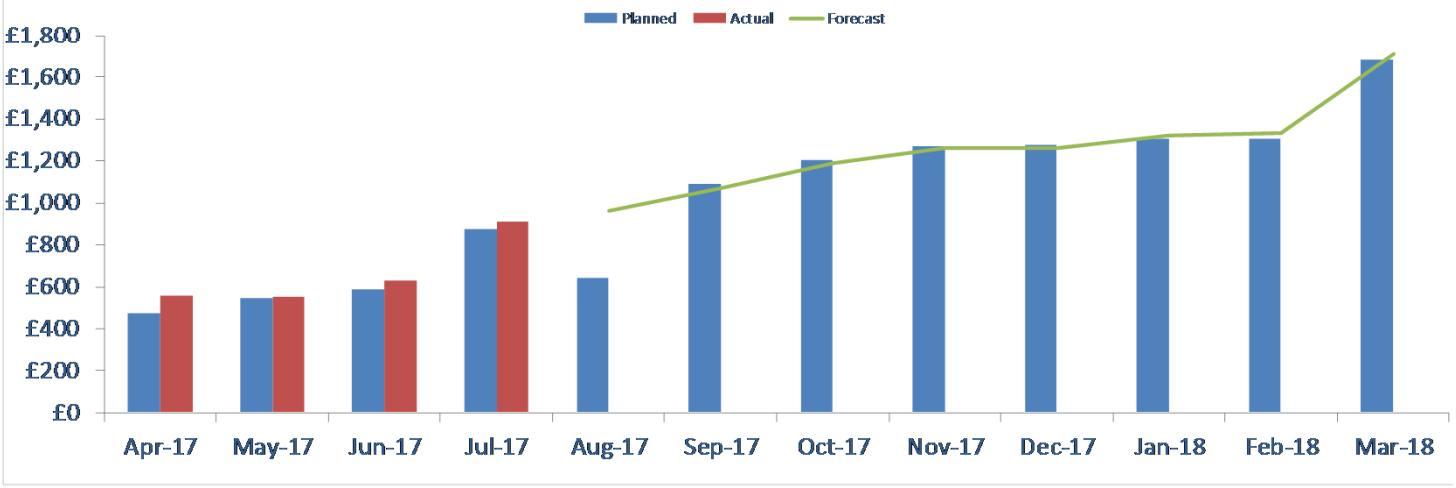
Of the 41 projects due to deliver savings in 2017/18, 37 Project Initiation Documents (PIDs) have been approved by the Transformation Executive Committee (TEC).

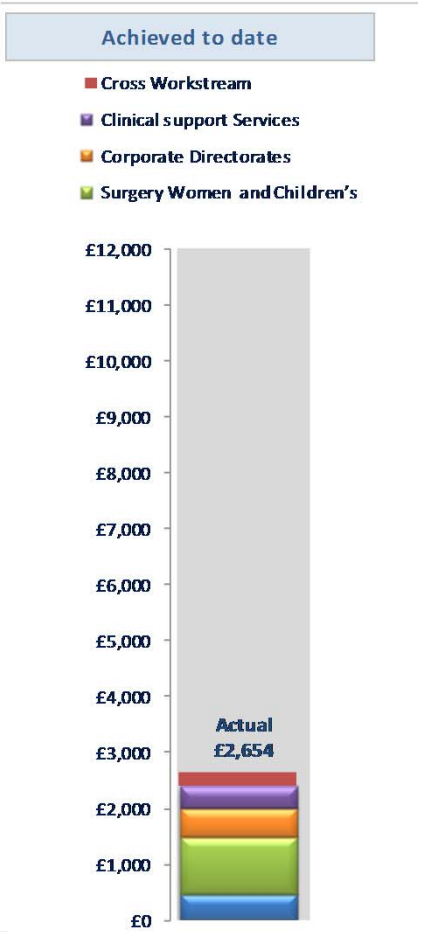
31 Quality Impact Assessments (QIAs) have now been approved by the panel with 4 pipeline scheme QIAs scheduled for panel on 16th August.

Executive Summary – 2017/18

	YTD	FYE			Submitted Plan
Planned	£2,537,384			Identified	£12,633,888
Actual	£2,653,665			Target	£12,500,000
Forecast		£12,711,589			
Variance	£116,281	£211,589			£133,888

Programme (Click for details)	YTD Plan	YTD Actual	YTD Variance	FYE Plan	FYE Forecast	FYE Variance
Surgery Women and Children's	£1,077,541	£1,024,093	-£53,448	£3,247,324	£3,258,179	£10,855
Medicine and Integrated Care	£345,968	£479,063	£133,095	£1,438,509	£1,457,197	£18,688
Clinical support Services	£300,409	£381,906	£81,497	£998,746	£1,308,485	£309,739
Corporate Directorates	£563,548	£517,654	-£45,894	£2,028,103	£1,869,870	-£158,233
Cross Workstream	£249,917	£250,949	£1,032	£4,921,205	£4,817,858	-£103,348
View all Projects	£2,537,384	£2,653,665	£116,281	£12,633,888	£12,711,589	£77,701





2017/18 Forecast Non Recurrent	£325,041
% of Total CIP Forecast as Non Recurrent	3%

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to the Board
7th September 2017

TITLE:	**Corporate Risk Register and Assurance Register Report**		
AUTHOR:	Sharon Phillips – Deputy Director of Governance (Risk and Standards)	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary
CORPORATE OBJECTIVES ALL			

Attached are the Corporate Risk Register and the Corporate Risk Assurance Report.

Corporate Risk and Assurance Register

The Corporate Risk Register records the Trust's key risks linked to each of the Trust's six objectives. The Register includes those key risks to the Trust's objectives as recorded with the Trust's annual plan (these are seen as the top down risks), it also includes those risks that have been escalated from the Trust's Divisions / Directorates (these are seen as bottom up risks). The tracking of risks can be seen in appendix 1.

The Corporate Assurance Register (appendix 2) shows the levels of the assurances received this quarter. The assurance register also records the level or origin of the assurance, from operational management through to an external source. As this assurance is collated across the year, Management and the Board are able to see the relative strength of assurance against each risk underpinning each objective.

The Corporate Risk Register and the Corporate Assurance Register have been considered by the Risk and Assurance Group and the Audit Committee and specific risks have also been considered by the Board Committees of Clinical Quality, Safety and Patient Experience, Finance and Performance and Workforce (reports provided for each Committee detailing the corporate risks for which they have oversight).

These Committee reviews confirmed the level of risk reflected in the Corporate Risk Register was appropriate at the time of their review.

It should also be noted that the Board itself also receives information on actions against some of the Corporate risks directly; these included those in respect of, DTOCs, Safer Staffing, Financial Sustainability and the MCP procurement again agreeing the level of risk reflected in the corporate risk register was appropriate.

Overview of current positon

The following table provides an overview of the current position with regards to the number of and value of the current risks when compared to the year end position for 2016/17

Number of risks as at March 2017	Number of risks as at July 2017	Total Risk Score March 2017	Total Risk Score July 2017
29	33 ↑	394	502 ↑

Summary of changes to the Corporate Risk Register

Assurance gaps

Assurance has been logged for all risks across the quarter.

New and Escalated risks

As this is a new year there are to be expected a number of new risks identified. There have been 7 new risks and 1 escalated risk added to the register within quarter 1 of the year.

COR244 – *Failure to Learn and Monitor from Deaths* - this was added in response to new national requirements and the need for improved assurance of the Trusts compliance

COR259 – *Friends and Family Testing outcomes* – this was in response to the Patient Survey identifying the Trust as one of the poorer performing Trusts nationally

COR121 *(esc) – Opthalmology Outpatient Appointment* Capacity - risk was escalated from the Division, although the overdue partial booking position had significantly improved, the ASI position had deteriorated. As a result of this, and the serious incidents reported over recent months the decision was made to escalate to a Corporate Risk supported by the CQSPE Committee.

COR241 – *Failure of the PFI providers to maintain the building in line with statutory requirements and to ensure a resilient estate* - this is in response to an increased number of contractual performance issues. This decision was supported by Finance and Performance Committee.

COR263 - *Management of Equality and Diversity matters for staff and services* - this is in response to a lack of assurance within this area. The decision was supported by the Workforce Committee.

COR234 – *Trust plans assume a significant level of income at risk from commissioners* – this is in response to trust activity levels. This has been supported by discussion at Finance and Performance Committee.

COR104 – *Failure of the PFI providers to manage the electrical infrastructure of the PFI buildings which is putting at risk the Trusts ability to deliver its clinical services* – the previous risk has been reviewed and its scope increased and therefore has for this year been classed as a new risk.

COR119 – *Failure to fulfil the costs and opportunities associated to the apprenticeship Levy* – this is in response to changes nationally in respect of the use of the new apprenticeship levy which effects the whole Trust. The issue has been discussed at the Board previously.

Risks where the current score has increased since the last meeting

There are **5 increased risks** within the 1st quarter of the year these have been discussed and agreed at both the Risk and Assurance Group and Audit Committee. These relate to:

COR080 – Failure to deliver 2017/18 Cost Improvement Programme (risk increased from 5-16) - the prior year score of 5 related to the 2016/17 outturn and the current risk of 16 relates to the new 2017/18 CIP programme

COR061 – Failure to remain financially sustainable in 2017-18 and beyond- (risk increased from 16 – 20) - 1 positive and 1 negative level 2 assurances (Report to Finance and Performance Committee identifying achievement of Q1 STF money but negative assurance over the current level of controls being consistently applied to control staffing costs for the rest of the year to the level within our initial financial plan).

COR086 – Patients' nutritional needs are not fully met during their hospital stay (risk increased from 4-16) – 1 positive level 1 assurance (launch of new nutritional assessment tool) – whilst positive assurance has been logged the performance against the Trust's quality priority remains below our set target.

COR087 – Inability to manage effectively the incidence of service acquired avoidable stage 3 and 4 pressure ulcers (risk increased from 8-12) – 1 positive level 1 assurance received of the pressure ulcer identification process having been reviewed and report presented to Quality and Safety Group but the Trust had had an increased number of grade 4 pressure ulcers in the community which means that the risk should increase.

COR097 - Risk of failing to reduce avoidable falls with harm to in-patients by a third by 2018 (risk increased from 12 – 15) – 3 positive level 1 assurances received (Report to Quality and Safety Group, active member of falls collaborate and reduced falls with harm in June. It was felt by the Executive and agreed by Risk and Assurance that whilst significant steps have been taken sustained improvement is still need for falls with harm before the risk should be reduced.

Risks where the current score has decreased since the last meeting

There is **1 risk where their score has decreased** within the 1st quarter of the year. These relate to:-

COR091 – The IT DR arrangements are not effective (risk decreased from 12 to 8) – 1 positive level 1 and 1 level 2 assurances have been logged (confirmed recovery for top 5 systems is 2-24 hours depending on disaster and DataCentre refresh programme (phase 1 and 2) approved by Board). These support the reduction in the current risk score.

De-escalated risks and Archived risks since the last report

There have been 3 risks that have been de-escalated in the 1st quarter of the year and 1 risk closed. The risks were de-escalated following review at Risk and Assurance Group and

moved into the Divisions risk registers. The Risk and Assurance Group were assured that immediate actions had been taken and the remaining actions required to mitigate were able to be delivered at Divisional level. With regard to the closed risk this area is itself closed therefore the risk can be closed.

De-escalated –

COR112 - The patient experience of patients with Autism is compromised as staff are not trained in Autism awareness to the level required.

COR114 - Failure to provide secure medicines related practice within the Trust

COR115 - Failure to provide safe storage of medical gas cylinder practice within the

Closed –

COR110 – B6 is an unfunded flexi ward area frequently opened to create extra capacity for the Turs for either medicine or surgery patients

No changes in Risk Score

There were 19 risks where the risk score remained the same, of these

- 7 risks had received a mix of both positive and negative assurance but it was felt the negative assurance was not significant enough to warrant a change in risk score. (**COR079, COR069, COR084, COR098, COR085, COR083, COR116**)
- 12 risks had received positive assurance but again the level of positive assurance at this time was not significant enough to warrant a change in score. (**COR099, COR108, COR111, COR101, COR244, COR032, COR100,COR096, COR263, COR089, COR103, COR 107**).

IMPLICATIONS OF PAPER:			
RISK	**Yes all risks**		**Risk Description: N/A**
	Risk Register: all on CRR		**Risk Score: N/A**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains but particularly well led**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD			
Decision	**Approval**	**Discussion**	**Other**
	Y	**Y**	

ACTION FOR THE BOARD

To confirm based on the review undertaken by the Risk and Assurance Group that the attached Risk Register reflects the key risks facing the Trust.

APPENDIX 1 CORPORATE RISK REGISTER

1. Risk Dashboard – rolling risk score trend

II	Risk Lead	Ref	Risk Title	Initial Risk Score	Current Risk Score					Trend	Target Risk Score
					30/06/16	30/09/16	03/01/17	14/03/17	31/07/17		
Objectives: SO1 Deliver a great patient experience											
F	COO	COR069	The Diagnostic Standard is at risk due to continuing demand for Imaging to support multiple pathways	20	16	20	20	20	20	➔	8
F	COO	COR079	Failure to meet the key performance targets	20	20	20	20	20	20	➔	8
CQSPE	CN	COR084	Failure to learn and be ready for the next CQC inspection	16	12	12	16	16	16	➔	8
CQSPE	DG	COR098	Failure to meet the expectations of the Accessible Information Standard	16	12	12	9	12	12	➔	8
F	COO	COR099	Failure to reduce the number of delayed transfer of care may result in poor patient experience	20	20	20	20	20	20	➔	16
F	DF	COR101	Capital Schemes fail to be delivered impacting on patient experience of the Trust	20	20	20	16	12	12	➔	8
CQSPE	CN	COR108 (NO41)	An inability to consistently maintain confidence in the quality of delivery of maternity care, resulting in negative reputation,	16	16	16	8	8	8	➔	8
F	DIT	COR111	The risk of a cyber-threat exploiting a vulnerability	16	NEW		16	16	16	➔	4
CQSPE	CN	COR112	The patient experience of patients with Autism is compromised as staff are not trained in Autism awareness to the level required	16	NEW		16	16	De-esc		8
CQSPE	COO	COR114	Failure to provide secure medicines related practice within the Trust	25	NEW		15	15	De-esc		8
CQSPE	COO	COR115	Failure to provide safe storage of medical gas cylinder practice within the Trust	20	NEW		12	12	De-esc		8
CQSPE	MD	COR244	Failure to Monitor and to Learn From Deaths	20				NEW	20		8
CQSPE	CN	COR259	Friend and Family Testing Outcomes					NEW	20		9
CQSPE	COO	COR121(OOS004)	Ophthalmology Outpatient Appointment Capacity	20				Esc	20		16
Objectives: SO2 Safe and Caring services											

II	Risk Lead	Ref	Risk Title	Initial Risk Score	Current Risk Score					Trend	Target Risk Score
					30/06/16	30/09/16	03/01/17	14/03/17	31/07/17		
F	COO	COR032	Trust Major Incident Plan does not deliver intended business continuity	15	10	10	10	10	10	→	10
CQSPE	CN	COR085	An inability to maintain the delivery of the safer staffing levels in relation to ward nurse staffing	20	20	20	20	20	20	→	10
CQSPE	CN	COR086	Patients' nutritional needs are not fully met during their hospital stay.	16	8	8	4	4	16	↑	8
CQSPE	CN	COR087	Inability to manage effectively the incidence of service acquired avoidable stage 3 and 4 pressure ulcers	12	12	9	9	8	12	↑	6
CQSPE	CN	COR096	Failure to prevent avoidable deterioration of patients leading to cardiac arrests	20	10	15	15	15	15	→	10
CQSPE	CN	COR093	Delays in the management of young people requiring section under the Mental Health Act (Tier 4)	20	16	12	12	12	12	→	8
F	DF	COR104	Failure of the PFI provider to manage the electrical infrastructure of the PFI buildings which is putting at risk the Trust's ability to deliver its clinical services.	16			NEW		12		4
CQSPE	CN	COR097	Risk of failing to reduce avoidable falls with harm to in-patients by a third by 2018.	15	9	9	9	12	15	↑	12
F	DF	COR100	Failure to comply with fire safety requirements	20	15	12	12	12	12	→	10
F	DF	COR241	Failure of the PFI provider to maintain the building in line with statutory requirements and to ensure a resilient estate	25			NEW		20		8
C	DHR	COR263	Management of Equality & Diversity matters for staff and services.	9			NEW		9		4
Objectives: SO3 Drive Service improvements, innovation and transformation											
CQSPE	COO	COR083	Failure to have a workforce/infrastructure that supports the delivery of 7-day working	20	16	16	16	16	16	→	15
F	DIT	COR089	EPR programme is delayed or fails to deliver benefits	16	16	16	12	16	16	→	12
Objectives: SO4 Be the place people choose to work											
W	DHR	COR102	The implementation of the revised JD contract may result in reduced availability of JD leading to gaps in rota	16	16	16	12	16	16	→	8
Objectives: SO5 Make the best use of what we have											
F	DF	COR234	Trust plans assume a significant level of income at risk from commissioners	20			NEW		20		15

II	Risk Lead	Ref	Risk Title	Initial Risk Score	Current Risk Score					Trend	Target Risk Score
					30/06/16	30/09/16	03/01/17	14/03/17	31/07/17		
F	DF	COR080	Failure to deliver 2017/18 Cost Improvement Programme	25	20	20	20	5	16	↑	12
F	DIT	COR091(FI003)	The IT DR arrangements are not effective	20	10	12	12	12	8	↓	4
CQSPE	COO	COR110	B6 is an unfunded flexi ward area frequently opened to create extra capacity for the Trust for either medicine or surgery patient	15	NEW		15	8	Arc		4
W	DHR	COR119	Failure to fulfil the costs and opportunities associated to the Apprenticeship Levy	12				NEW	8		6
Objectives: SO6 Deliver a viable future											
F	DF	COR061	Failure to remain financially sustainable in 2017-18 and beyond	20	16	16	16	16	20	↑	16
F	MD	COR103	Potential Multispecialty Community Provider procurement impacts on Trust sustainability	16	20	20	16	16	16	→	8
F	MD	COR107	Delivery and implementation of the STP is not wholly consistent with Trust's own business strategy	16	16	16	16	9	9	→	6
F	COO	COR116	High dependency on agency staff particularly in clinical areas	25	16	16	20	20	20	→	4

Key for Risk Lead			Key for Strategic Objectives			Key for source of assurance	Key for assurance grading
CE	Chief Executive		**SO1:**	Deliver a great patient experience		**Level 1 – assurance provided by Operational Management**	**G reen** **ALL** Positive assurance
MD	Medical Director		**SO2:**	Safe and Caring Services		**Level 2 – assurance provided by Executive Manangement / Board Committee**	**A mber** **A MIX** of positive and negative assurance
CN	Chief Nurse		**SO3:**	Drive service improvements, innovation and transformation		**Level 3 – assurance provided by an external source**	**R ed** **ALL** Negative assurance
DF	Director of Finance and Information		**SO4:**	Be the place people choose to work			**A blank indicates no asurance was noted for that quarter**
COO	Chief Operating officer		**SO5:**	Make the best use of what we have			
DSP	Director of Strategy and Business Planning		**SO6:**	Plan for a viable future			
DG	Director of Governance						
DHR	Director of HR						
DIT	Director of IT						

APPENDIX 2 CORPORATE RISK ASSURANCE SUMMARY

2. Assurance Dashboard – rolling assurance trend

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Target Risk Score
					Risk June 2017	Level 1	Level 2	Level 3	Risk Sept 2017	Level 1	Level 2	Level 3	
SO1	COO	COR079	Failure to continue to deliver the key contracual / monitor deliery targets (18wks / ED / Cancer)	20	20		A						8
	COO	COR069	Diagnositc standard is at risk if the demand rises to a level above capacity	20	20	G	R						8
	CN	COR084	Failure to learn and be ready for our next CQC inspection*	16	16		A						8
	DG	COR098	Failure to comply with Accessible Information Standard	16	12	A							8
	COO	COR099	Failure to reduce the number of delayed transfer of care may result in poor patient experience and may impact on patient safety, as patients will have to be managed in outlying / contingency areas	20	20	G							16
	CN	COR108	An inability to consistently maintain confidence in the quality of delivery of maternity care,	16	8		G	G					8
	DIT	COR111	Risk of cyber threat exploiting a vulnerability to threaten confidentiality, availabiliyt or integity of data services	16	16	G		G					4
	DF	COR101	The risk to the delivery of the number of capital schemes the Board would like to commit to which require external financial support	20	12	G	G						15
	CN	COR259	Family and Friends testing outcomes	20	20	G							9
	COO	COR121(OOS004)	Ophthalmology Outpatient Appointment Capacity	20	20		A						16
	MD	COR244	Failure to Monitor and to Learn from Deaths	20	20		G						8
SO2	COO	COR032	The Trust is required to have an up to date plan to manage major incidents and business continuity.	15	10	G							10
	DF	COR104	Failure of the electricty supply to Hospital Site	16	12	R							4

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Target Risk Score
					Risk June 2017	Level 1	Level 2	Level 3	Risk Sept 2017	Level 1	Level 2	Level 3	
	CN	COR085	Failure to maintain the delivery of safer staffing levels in relation to ward nurse staffing	20	20		A						10
	CN	COR086	Patients' nutritional needs are not fully met during their hospital stay	16	16	G							8
	CN	COR087	An inability to reduce the incidence of hospital and community service acquired avoidable stage 3 and 4 pressure ulcers to an acceptable level resulting in suboptimal care for patients	12	12	G							4
	CN	COR093	Management of young people requiring care under the mental health act (tier 4 beds are not available)	20	12		A						8
	CN	COR097	Fail to achieve the best practice target for falls in hospital	15	15	G							12
	DF	COR100	Failure to comply with fire safety requirements	20	12	G							10
	CN	COR096	Failure to prevent avoidable deterioration of patients leading to cardiac arrests	20	15	G							10
	DHR	COR263	Management of Equality & Diversity matters for staff and services.	9	9	G							4
	DF	COR241	Failure of the PFI provider to maintain the building in line with statutory requirements and to ensure a resilient estate	25	20		G						8
S03	COO	COR083	Failure to have a workforce / infrastructure that supports the delivery of 7 day working	20	16		A						15
	DIT	COR089	EPR programme is delayed and fails to deliver expected benefits **	16	16		G						12
SO4	COO	COR102	The implementation of the revised JD contract may result in reduced avaiavility of JD leading to gaps in rotas	16	16		A						8
SO5	DIT	COR091	The IT DR arrangements are not effective	20	8		G						4
	DSP	COR080	Failure to deliver our CIP programme **	25	16		G						12
	DF	COR234	Trust plans assume a significant level of income at risk from commissioners	20	20		G						15
	DHR	COR119	Failure to fulfil the costs and opportunities associated to the Apprenticeship Levy	12	8		A						6

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Target Risk Score
					Risk June 2017	Level 1	Level 2	Level 3	Risk Sept 2017	Level 1	Level 2	Level 3	
SO6	DF	COR061	Failure to maintian financial sustainability	20	20		A						16
	DSP	COR103	Potentail for MCP procurement exercise adversly impacts on Trust sustainability	16	16	G							8
	COO	COR116	High dependency on agency staff, particularly in clinical areas, is contributing to high levls of expenditure on pay and also contributing to an inconsistent workforce delivering care to patients.	25	20	G	A						4
	DSP	COR107	The agreed outcome of the STP is not aligned with the current Trust Business Strategy	16	9	G	A						6

Key for Risk Lead			Key for Strategic Objectives			Key for source of assurance	Key for assurance grading
CE	Chief Executive		**SO1:**	Deliver a great patient experience		**Level 1 – assurance provided by Operational Management**	**G reen** **ALL** Positive assurance
MD	Medical Director		**SO2:**	Safe and Caring Services		**Level 2 – assurance provided by Executive Manangement / Board Committee**	**A mber** **A MIX** of positive and negative assurance
CN	Chief Nurse		**SO3:**	Drive service improvements, innovation and transformation		**Level 3 – assurance provided by an external source**	**R ed** **ALL** Negative assurance
DF	Director of Finance and Information		**SO4:**	Be the place people choose to work			**A blank indicates no asurance was noted for that quarter**
COO	Chief Operating officer		**SO5:**	Make the best use of what we have			
DSP	Director of Strategy and Business Planning		**SO6:**	Plan for a viable future			
DG	Director of Governance						
DHR	Director of HR						
DIT	Director of IT						

Enclosure 18

The Dudley Group NHS Foundation Trust

CALENDAR 2018

	Board of Directors	Board Workshops (half days)	Finance & Performance Committee	Workforce and Staff Engagement	Clinical Quality, Safety & Patient Experience	Charitable Funds Committe	Audit Committee	Digital Trust Committee	Council of Governors	Annual General Members Meeting	Strategy Workshops 18.00 – 20.00	Strategy Committee 18.00 start	Governance Committee 18.00 start	Engagement and experience Committee 16.30 start	Governor Development Group	Internal Safeguarding Board	Patient Experience Group	Arts and Environment Group	EoL & Palliative Care Strategy	Risk and Assurance Group	Caldicott and Information Governance	Medicine and Integrated Care Division 10am-12pm	Surgery Division 12.45pm-2.45pm	Support Services Division 3-5pm	TEC 10am-12pm	Clinical Approvals Group
JAN 2018	11		25		23		30	24						17						10	18$	16#	16$	15$	18#	31
FEB 2018	8	15	22	27$	27#	22		21			20		22		22							20#	20$	19$	14#	28
MAR 2018	8		29		27		19	21	8			6									6	20#	20$	19$	21$	28
APR 2018	12		26	24$	24#			18					19	18	24					11		17#	17$	16$	19#	25
MAY 2018	3	10	31		29	31	22	23			22											15#	15$	14$	24#	30
JUNE 2018	7		28	26$	26#			20	7			5	14£								5	19#	19$	18$	21#	27
JULY 2018	5		26		24			18						4						11		17#	17$	16$	19#	25
AUG 2018	2	2*	30	28$	28#	30	20	22			14	28			21							21#	21$	20$	22$	29
SEPT 2018	6		27		25			19	6				27								11	18#	18$	17$	20#	26
OCT 2018	4		25	23$	23#			17						17						10		16#	16$	15$	18#	31
NOV 2018	1	8	29		27	29	19	21			20				13						6	20#	20$	19$	21$	28
DEC 2018	6		20	18$	18#			19	6			4	20									18#	18$	17$	13#	29

NOTES

* If not a board meeting # morning meetings $ afternoon meetings

Governors Annual Members Meeting date has still to be confirmed £ this will be an open meeting for ALL governors to meet with the External Auditors

Enclosure 19

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors
On 7th September, 2017

TITLE:	**Trust Annual Plan 2017/18: Quarter One Report**		
AUTHOR:	**Lisa Peaty** **Deputy Director: Strategy & Performance**	**PRESENTER**	**Lisa Peaty** **Deputy Director: Strategy & Performance**
CORPORATE OBJECTIVE: **All Objectives**			

SUMMARY OF KEY ISSUES:

The full performance report for the Trust's Annual Plan can be found in Appendix One. The summary of the **Quarter One** position is:

Strategic Objective	RAG rating			
	Red	Amber	Green	No Status
Deliver a great patient experience	3	5	2	5
Deliver safe and caring services	2	14	4	0
Drive service improvement, innovation and transformation	3	14	2	4
Be the place people choose to work	0	4	5	7
Make the best use of what we have	0	2	4	0
Plan for a viable future	0	3	3	6
Total	8	42	20	22

Eight measures of achievement are rated as red as outlined below. Mitigating actions are in place for these measures of achievement, six of which are also on either the Corporate or Divisional Risk Registers. It is proposed that the two measures of achievement rated as red which are not currently listed on a risk register are added to the relevant risk register.

- Deliver a great patient experience
  - 95% emergency access standard met (Corporate Risk 079)
  - 62 day wait for first treatment for cancer (Corporate Risk 079)
  - Six week wait for diagnostic procedures (Corporate Risk 068)

- Safe and caring services
  - Serious incidents managed in line with national standards
  - Monthly trajectory towards £3.73m cap on agency spend (Corporate Risk 116)

- Service improvement, innovation and transformation
  - Recruitment and retention strategy for theatre staff
  - Reduced waiting time for Ophthalmology (Corporate Risk 121)
  - Increase pharmacy prescribers to 70% (Divisional Risk CSS293)

The summary of the **forecast Quarter Two** position is:

Strategic Objective	RAG rating			
	Red	Amber	Green	No Status
Deliver a great patient experience	1	6	3	5
Deliver safe and caring services	0	11	9	0
Drive service improvement, innovation and transformation	1	18	2	2
Be the place people choose to work	0	5	5	6
Make the best use of what we have	0	2	4	0
Plan for a viable future	0	2	4	6
Total	2	44	27	19

The forecast Quarter Two position is an improvement when compared to Quarter One.

- 7 more greens compared to Quarter One
- 6 fewer reds compared to Quarter One
- 2 more ambers compared to Quarter One
- 3 fewer indicators are grey compared to Quarter One

A trajectory of performance into quarters three and four can be found in Appendix Two. This suggests that performance will continue to improve.

The Trust's **Clinical Strategy** was approved by Trust Board in August 2017. The strategy includes a range of initiatives which will be implemented during 2017/18 and sets out an aspiration to monitor the progress of these through the annual planning process. These include:

- Develop MSK Services
- Develop a model to support Acute Oncology Service
- Expansion of community ENT clinics (including Audiology)
- Review of provision of plastics/skin cancer services
- Develop a more integrated clinical model for therapy services
- Expansion of orthodontics service

It is proposed that these initiatives are added to the Trust's Annual Plan and monitored from Quarter Two.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: All**
	NHSI	**Y**	**Details:**
	Other	**N**	**Details:** Operational Plan is submitted to & approved by NHSI

ACTION REQUIRED OF BOARD OF DIRECTORS

Decision	Approval	Discussion	Other
Y		**Y**	

The Dudley Group NHS
NHS Foundation Trust

RECOMMENDATIONS FOR BOARD OF DIRECTORS

- The outcome of Quarter One and forecast outcome for subsequent quarters for each of the goals is noted.
- Confirm whether the proposed mitigating actions are sufficient to improve performance.
- Confirm whether measures of achievement rated as red in Quarter One which are not currently listed on a risk register should be added to the relevant risk register
- Confirm whether additional actions should be added to the Annual Plan to reflect the initiatives highlighted in the Clinical Strategy

Appendix One

†† **- denotes initiatives contained in the Clinical Strategy**

The Dudley Group NHS
NHS Foundation Trust

Operational Plan 2017/18

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
Strategic aim one: deliver a great patient experience					
✓ **Improve engagement and involve patients, carers and the public in their care and the work of the Trust** ✓ Implement approaches that engage and involve patients, carers and the public in their care / service developments and provide opportunities for feedback ✓ Improve the FFT response rate trust-wide ✓ Further develop mechanisms to implement learning from feedback. ✓ Increase the use of Listening into Action (LIA) with Patient Groups	✓ *Percentage positive monthly FFT/patient survey scores equal to or better than the national average for all areas (Inpatients, Outpatients, Maternity, Emergency Department and Community).*	March 2018	Chief Nurse		**Progress update and risks to delivery**: This has been achieved in Maternity with a footfall score of 40.4%, Emergency Department with a footfall score of 17.1%, and Inpatients with a footfall score of 32.8%. It has not been not been achieved in Outpatients (footfall score 2.3%) and Community (footfall score 2.1%). **Mitigating actions**: Dedicated work is being undertaken with local and trust wide actions plans developed to deliver improvement actions monitored by the Patient Experience and Improvement Group,. Dedicated patient experience volunteers introduced for inpatient areas.
	✓ *An agreed 6 month trajectory of improvement until the monthly FFT response rate is equal to national average.*				**Progress update and risks to delivery**: Six month trajectory has been agreed in quarter one. **Mitigating actions**: These include the: • launch of FFT across the trust • Introduction of Feedback Friday • Introduction of dedicated patient experience volunteers
	✓ *Annual National Patient Survey results equal to or better than the national average.*				**Progress update and risks to delivery**: This indicator is grey as the results of the survey are not due until quarter 4. Results for last few years are poor and there is a risk that 2017/18 patients who are surveyed will not have experience positive changes yet.

Appendix One

†† - denotes initiatives contained in the Clinical Strategy

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
					Mitigating actions: All areas have action plans in place to improve the results for next year. Local surveys will be introduced to demonstrate improvements.
	✓ *Undertake LIA with patients groups for example dementia, learning disability and end of life*				**Progress update and risks to delivery**: LIA events are in the planning stage with plans in place for quarter 2. **Mitigating actions**: Head of Patient Experience will be appointed in July 2017.
✓ **Maintain high performance in national operational performance standards:** • **Urgent care** • **Patient flow** • **Delayed transfers of care** • **Imaging** • **Cancer** • **Referral to treatment time** ✓ Rebuild and reconfigure the UCC to provide more effective front door streaming ✓ Deliver best practice models for discharge ✓ Work in partnership with Dudley and Walsall Mental Health (MCP) to	✓ *95% emergency access standard met.*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: The red to green process in medicine wards is in place but there has been failure over recent months to deliver weekly and monthly A&E target. There is inconsistent use of Expected Date of Discharge and few discharge plans in place. **Mitigating actions** include a patient flow programme in place; an external review of current systems to improve delivery of red to green; weekly review of performance and forward look.
	✓ *Best practice models for discharge delivered*				**Progress update and risks to delivery**: DTOC Action for health economy in place. **Mitigating actions** include a patient flow plan which incorporates management of expected date of discharge and reduction in 'wasted days'; external review of supporting areas of useful focus; through iBCF funding, increased discharges through home based care and assessment in the community being delivered in September 2017.
	✓ *Additional Mental Health Crisis team support available*				**Progress update and risks to delivery**: The Mental Health Crisis Team support is already available through A&E and plans are in place to develop this further through the A&E Delivery Plan. **Mitigating actions**: work ongoing with the

Appendix One

†† - denotes initiatives contained in the Clinical Strategy

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
improve 24 hour access to mental health services in A&E ✓ Deliver the Dudley Health Economy Delayed Transfers of Care Improvement Plan (High Impact Change Model) ✓ Develop and implement a demand and capacity plan to deliver definitive cancer diagnosis within 28 days ✓ Assess the potential impact of Rapid Diagnostic Centres on the Trust's activity in conjunction with neighbouring trusts. ✓ Implement community imaging hub at The Guest Outpatients Centre to increase capacity ✓ Meet the 18 weeks referral to treatment standard across all specialties					Mental health team to expand service.
	✓ *Reduce Delayed Transfers of Care from March 2017 baseline*				**Progress update and risks to delivery**: There has been a reduction on the total number of DTOCs previously in Quarter One. More work to improve required. **Mitigating actions** include an internal daily review to check ward-based assessments; review format of daily site meeting to inform decisions to progress on discharge; top 20 meeting re-initiated; iBCF funding to support community assessments rather than hospital based.
	✓ *Maximum 62day wait for first treatment from: i) urgent GP referral for suspected cancer ii) NHS cancer screening service referral*				**Progress update and risks to delivery**: A Cancer Action Plan has been developed and is being progressed. Additional support monies from NHSI have been applied for and in the case of Urology agreed (1 further bid pending for short-term project management support and additional Histopathology capacity). Offer from IST to provide analysis and support with visit to site expected within the next 3 weeks. **Mitigating actions** include an internal cancer action plan based on good practice tools; external review of processes being undertaken by IST; external Cancer Board meeting; weekly review of performance.
	✓ *National Cancer Dashboard in place*				**Progress update and risks to delivery**: The Trust already contributes to the current national cancer dashboard and will ensure that it complies with the implementation of the national dashboard as it is rolled out nationally. **Mitigating actions**
	✓ *Six week wait for diagnostic procedures (99%)*			95.7%	**Progress update and risks to delivery**: Action Plan produced with short, medium and longer term actions identified. Currently, improved performance against trajectory in

Appendix One

†† - denotes initiatives contained in the Clinical Strategy

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
					quarter 2. Recovery of target expected in September 2017. **Mitigating actions** include ongoing implementation of actions associated with improvement trajectory; increased mobile working for some modalities; weekly performance meetings against target; implementation of Guest CT and MRI suite to provide additional elective capacity.
	✓ *RTT – 92% of incomplete pathways*				**Progress update and risks to delivery**: On-going monitoring via RTT team. **Mitigating actions**:
✓ **Redesign a number of integrated pathways and services as a partner in the MCP** †† ✓ Further develop the redesign of community nursing services to deliver MCP aims ✓ Implement community based consultant services in elderly care, respiratory, diabetes and paediatrics ✓ Work closely with primary care to optimise the outcomes of the MCP	✓ *To be determined on the outcome of procurement* ✓ *Clinics in place* ✓ *Regular discussion in place with practices and localities*	March 2018	Medical Director/ Chief Operating officer		
Strategic aim two: deliver safe and caring services					

Appendix One

†† - denotes initiatives contained in the Clinical Strategy

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
➢ **Deliver the Trust's Quality Strategy Priorities** ✓ Implement the priorities within the Trust's Quality Strategy • Pressure ulcers • Infection control • Nutrition and hydration • Medication management ✓ Improve delivery in incident management ✓ Review the use of National Early Warning Scores to identify deteriorating patients and minimising impact ✓ Deliver the action plan on the reduction in patient falls within the Trust	✓ *Targets outlined in the Trust's Quality Strategy achieved: zero Pressure ulcers: hospital and community* • *Ensure that there are no avoidable stage 4 hospital and community acquired pressure ulcers throughout the year.* • *Ensure that the number of avoidable stage 3 hospital and community acquired pressure ulcers in 2017/18 reduces from the number in 2016/17.*	March 2018	Chief Nurse		**Progress update and risks to delivery**: Investment in Tissue Viability team. **Mitigating actions**: The Tissue Viability Team is providing additional training on the recognition and optimal management of pressure ulcers to support delivery of this target.
	✓ *Targets outlined in the Trust's Quality Strategy achieved.* *i) Infection control* • *Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley CCG to agree on any avoidability/lapses in care.*				**Progress update and risks to delivery**: Targets have been achieved. A risk surrounds the new national definition of 'lapse in care' which now includes staff being not compliant with mandatory training. **Mitigating actions**: Training methods are being diversified and availability of training increased. Continual monitoring of infection control processes are in place.
	✓ *Targets outlined in the Trust's Quality Strategy achieved.* *Nutrition and hydration (CLM) - Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items):* • *is 95% or above in each of the first three quarters for the Trust as a whole* • *has a 'Green' rating (95% or above) in the final quarter for every ward in the hospital*				**Progress update and risks to delivery**: Two of the three targets were achieved in quarter one. A risk includes the use of temporary staff and capacity issues. **Mitigating actions** include increased staffing on wards, increased focus in this area, close monitoring and action.
	✓ *Targets outlined in the Trust's Quality Strategy achieved.* *Pain and Medication management*				**Progress update and risks to delivery**: one of the two targets has been achieved. A risk includes the use of temporary staff and

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
	(CLM) • *Ensure that in 95% or more cases, all prescribed medications will either be: a) signed and dated as administered or b) have an omission code recorded.*				capacity issues. **Mitigating actions** include increased staffing on wards, increased focus in this area, close monitoring and action.
	✓ *Reduce the number of omitted medication errors by 50%*				**Progress update and risks to delivery** A missed dose audit was carried out by pharmacy in May 2017. There has been a slight reduction in the number of omitted medication incidents. In 2016/17, the average number per quarter was 31, quarter 1 2017/18 is 28 **Mitigating actions** include increased staffing on wards, increased focus in this area, close monitoring and action. Monthly audits will be introduced in quarter 2. Link nurses will be introduced in August 2017.
	✓ *Incident reporting rate increase by 10% each Quarter*				**Progress update and risks to delivery**: Latest comparative figures for April to September 2016 were published in March 17. The Trust reporting rate was 97th of 136 organisations which is towards the bottom of the 3rd quartile. Risks include the time taken to achieve cultural change required to improve reporting. **Mitigating actions**: Publicity on ensuring that incidents are closed in a timely fashion. This is being monitored.
	✓ *All serious incidents to be managed in line with national Standards: All Serious incidents, including Never Events, sent to commissioners within 60 days*				**Progress update and risks to delivery**: In Q1, 11 RCAs were in breach of the 60 day deadline. All have now been submitted. **Mitigating actions**: An escalation process from Governance team to Chief Nurse has been established.
	✓ *Best practice (aligned with partner specialist provider) National Early Warning Systems (NEWS) in place including*				**Progress update and risks to delivery**: NEWS implementation is on course for early August 2017.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
	Paediatric Early Warning Systems (PEWS), Modified Obstetric Early Warning System (MOEWS)(CLM)				**Mitigating actions**: Training for staff on the use of NEWS is currently underway.
	✓ *Reduce the number of avoidable falls that result in harm in our inpatient services by a third (PS/JP)*				**Progress update and risks to delivery**: Q1 16/17 = 1 avoidable fall. Q1 17/18 = 4 falls with harm, 1 confirmed unavoidable, 3 others to be confirmed post RCA approval. The June 2017 falls report identified the lowest inpatient falls incidence since August 2015 (all falls). **Mitigating actions**: 20 x High/low beds are in place with 30 more on order. A falls improvement plan is in place.
➢ **Deliver agreed CQUIN requirements** ✓ Develop and deliver all CQUIN schemes	✓ *CQUIN schemes are delivered to expected levels*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: All CQUIN schemes have appropriate project documentation completed. 9 of the 11 CQUINs are on track to fully deliver. Quarter 1 partial achievement only for Sepsis treatment within 1 hour which achieved 76% against a target of 90%. From quarter 2 there is some risk to delivery of the CQUINs relating to discharge and medicines optimisation due to national changes in timescales relating to IT systems. **Mitigating actions**: include a Sepsis ED recovery plan with regular monitoring and confirm and challenge meetings which should enable the trust to fully achieve targets from quarter 2. Risks to the achievement of the discharge and medicines CQUINs have been escalated to NHS Digital and SpecCom
➢ **Maintain good mortality performance**	✓ *SHMI/HSMR within expected range*	March 2018	Medical Director		
	✓ *100% of hospital deaths have a*				

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
✓ Continue to develop arrangements for learning from the death of patients in our care, including publication of data	*multidisciplinary review*				
Deliver Safe staffing levels ✓ Ensure all clinical areas are staffed to Best Practice Standards, including all ward and community teams ✓ Review of Allocate Rostering System ✓ Review all of Trust's Clinical Nurse Specialists (CNS) ✓ Implementation of Job Planning for all Consultant posts	✓ *50% Reduction in use of agency staff*	March 2018	Chief Nurse/ Medical Director/ Director of HR		**Progress update and risks to delivery**: A small reduction in agency usage has been noted since the implementation of the new control measures. Non recruitment of substantive staff is the main risk. **Mitigating actions**: A revised agency authorisation proforma is now in use, supporting overall reduction in agency use. The use of agency CSWs is no longer permitted. Tighter control on the use of non-framework agency for registered staff is in place. A nurse recruitment and retention lead post is planned.
	✓ *Monthly trajectory toward the full year target of £3.73m cap on maternity and nursing bank and agency spend is met*				**Progress update and risks to delivery**: The trajectory for quarter 1 is £1.38m and spend is £1.1m. Monthly spend: April =£0.45m, May = £0.54m, June =£0.39m. The main risks are ongoing vacancies and non- recruitment of substantive staff. **Mitigating actions**: A staffing review is in progress and a recruitment plan in place.
	✓ *Substantive staffing in place to cover agreed establishment requirements in both the community and hospital areas. Ensure that there is a reduction in vacancy rates.*				**Progress update and risks to delivery**: A staffing review is in progress. Surgical areas medical reviews will be completed by August. The main risk is non recruitment of substantive staff. **Mitigating actions**: Costings being assessed. These will be finalised mid-August. Nurse recruitment and retention lead post planned.
	✓ *Job Plans in place for consultants and specialist doctors*				**Progress update and risks to delivery**: Policy has been updated and agreed, and a programme of work has been agreed. Data

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
					collection for job plans is being undertaken in divisions. **Mitigating actions**: Data collection for job plans is being undertaken in divisions.
➢ **Deliver improvements in maternity care** ✓ Develop and implement the Maternity Transformation Programme (Better Births) ✓ Deliver improved maternity dashboard	✓ *Reduce neonatal deaths*	March 2018	Chief Nurse		**Progress update and risks to delivery**: The draft 5 year plan for Maternity Transformation is being written by the Black Country LMS for submission to the National Maternity board in October 2017. **Mitigating actions**: There are tree work streams currently in progress particularly the Infant Mortality work stream building on existing good practice across the Black Country.
	✓ *Reduce babies with brain injuries that occur at or soon after birth*				**Progress update and risks to delivery:** The draft 5 year plan for Maternity Transformation is being written by the Black Country LMS for submission to the National Maternity board in October 2017. **Mitigating Actions:** There are tree work streams currently in progress particularly the Infant Mortality work stream building on existing good practice across the Black Country.
	✓ *Zero avoidable maternal deaths*				**Progress update and risks to delivery**: The draft 5 year plan for Maternity Transformation is being written by the Black Country LMS for submission to the National Maternity board in October 2017. **Mitigating actions**: There are tree work streams currently in progress particularly the Infant Mortality work stream building on existing good practice across the Black Country.
	✓ *Progress towards key maternity dashboard*				**Progress update and risks to delivery**: A draft updated dashboard has been developed in quarter 1. **Mitigating actions**: The dashboard is being

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
					rolled out in August 2017.
Strategic aim three: drive service improvement, innovation and transformation					
➢ **Deliver effective medical research activities** ✓ West Midlands CRN Higher Level Objectives (HLO 1-3) achieved.	✓ *West Midlands CRN Higher Level Objectives (HLO 1-3) achieved*	March 2018	Medical Director		**Progress update and risks to delivery**: This action is being reviewed
✓ **Increase access to 7 day services** †† ✓ Implement plans to deliver key standards ✓ Actively contribute to appropriate clinical networks to deliver seven day services for emergency vascular surgery, stroke, major trauma, heart attacks and paediatric intensive care	✓ *Improve the position from the audit completed in April 2016 for:* • *first consultant review in 14 hours*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: Directorates have implemented a number of initiatives to secure review by a consultant in 14 hours though compliance cannot be confirmed until a further audit is undertaken. **Mitigating actions**: Directorates have submitted plans to improve 14 hour access and these are being reviewed by Medical Director and Chief Operating Officer.
	✓ *Improve the position from the audit completed in April 2016 for:* • *Consultant directed intervention*				**Progress update and risks to delivery**: Many services are available already on site or through SLAs. **Mitigating actions**: A plan is in place for Interventional Radiology to be in place for December 2017; a plan is in place to extent MRI provision through the community imaging hub and a plan for interventional endoscopy is being developed.
	✓ *On-going review of high-dependency patients by consultants twice daily*				**Progress update and risks to delivery**: Delivered in most of high dependency areas, but more work is required in some with plans to support. **Mitigating actions**: Meetings are in place to support plans in these areas doe Vascular/Surgical/Medical HDU.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
	✓ *Improve the position from the audit completed in April 2016 for:* • *Timely access to diagnostics*				**Progress update and risks to delivery**: with community imaging suite, the timescale for delivery should be March 2018 **Mitigating actions** include a current review of capacity and workforce to support delay of timescales to March 2018.
	✓ *Trauma network peer review recommendations implemented*				**Progress update and risks to delivery**: All recommendations are being reviewed for implementation by the directorate. some actions have been completed (eg Governance structure). **Mitigating actions**: Work is taking place between Directorate Manager and clinical teams to implement the recommendations, including working towards an ED Level 2 trained Trauma nurse being on shift 24/7 and appointing a Trauma Coordinator.
➢ **Transform and re-organise services to drive efficiency and improve key services** ✓ Deliver phase two of Outpatients Transformation ✓ Implement theatres transformation plans ✓ Develop and implement plans for the hybrid theatre ✓ Address performance challenges in ophthalmology	✓ *Referral and clinical management processes reviewed and new processes implemented*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: Progress has been made on letter review and a plan is in place to progress advice and guidance and delivery of e-referrals.. **Mitigating actions**: Further work being undertaken through OPD performance meeting which includes reduced clinic cancellations and improved ASI performance, improved slot utilisation, improved oversight of follow ups through partial booking implementation.
	✓ *Records management processes reviewed and new processes implemented*				**Progress update and risks to delivery**: Processes internally have been reviewed and changed to support operational delivery. . **Mitigating actions**: Further work required on notes delivery for theatres and OPD.
	✓ *Recruitment and retention strategy for theatre staff in place*				**Progress update and risks to delivery**: April/May- high level of Band 5 leavers for external opportunities at band 6 and above. Opportunities externally. External review has

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
✓ Implement the GIRFT recommendations for relevant specialities ✓ Develop and deliver improved pathways for MSK, Respiratory and Neurology in line with the RightCare initiative to reduce unwarranted variation †† ✓ Improvements in service performance delivered for Renal ✓ Implement the Hospital Pharmacy Transformation Plan (HPTP) ✓ Implement improvements to hospital discharge process					identified areas for focused improvement. **Mitigating actions** include increasing geography for university graduates has resulted in recruitment from Stoke area. Theatres to take an active part in the Trust Recruitment Days in August/September; continue rolling advert on NHS Jobs for Band 5 Anaesthetics & Recovery Practitioners; implementation of external review.
	✓ *Theatre scheduling undertaken using EPR*				**Progress update and risks to delivery**: EPR project is on-going. Vacancies now recruited. Improved delivery from August 2017. **Mitigating actions**: Action plan is now about to be delivered.
	✓ *Phase two of theatre reconfiguration complete*				**Progress update and risks to delivery**: Further work being undertaken with an external company. **Mitigating actions**: Action plan to improve as per external review.
	✓ *Hybrid Theatre business case written and approved* ✓ *Hybrid theatre implementation*				**Progress update and risks to delivery**: The business case has been written and approved, plans in place to build within 2018/19. **Mitigating actions**: Progressing with architectural planning.
	✓ *Reduced waiting time for ophthalmology*				**Progress update and risks to delivery**: A number of pathway improvements are already in place and the service is working to improve capacity further as below: • Nurse injector to start interdependent theatre sessions • Minor Eye Conditions to go out in the community • Virtual Glaucoma Pathway with Oct Cirrus **Mitigating actions**: Use of private company to expedite clearing the waiting list and reduce ASI for August 2017.
	✓ *Hip prosthesis rationalised*				**Progress update and risks to delivery**:

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
					Savings have been realised
	✓ *ENT day case rates improved*				**Progress update and risks to delivery**: Day case rates have been optimised within ENT and all clinically appropriate patients are admitted as day cases.
	✓ *Consultant physician input to vascular surgery in place*				**Progress update and risks to delivery**: A business case is in draft form in the finance department, planned for approval within September. Working with Elderly Care department to secure locum. **Mitigating actions**: Employment of consultant locum for winter period being reviewed.
	✓ *Implement actions from Ophthalmology GIRFT Review*				**Progress update and risks to delivery**: Ophthalmology action plan developed and presented at CQSPE. **Mitigating actions**: Plans to engage with a private company to clear backlog of 100 new and 650 follow up patients.
	✓ *Improved pathways developed, agreed and implemented Ophthalmology*				**Progress update and risks to delivery**: In Ophthalmology a number of pathway improvements are already in place and the service is working to improve capacity further as below: • Nurse injector to start interdependent theatre sessions • Minor Eye Conditions to go out in the community • Virtual Glaucoma Pathway with Oct Cirrus **Mitigating actions**: Consultants are doing extra clinics to mitigate risks and engaging with the private company.
	✓ *Improvement in efficiency (metrics to be approved once plan approved)*				**Progress update and risks to delivery**: The plan is in place to improve theatre efficiency and is linked with CIP

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
	✓ *Increase clinical pharmacy time by 80%*				**Progress update and risks to delivery**: Performance against this metric is deteriorating due to a number of people leaving, creating increased vacancies and pressure on the department. **Mitigating actions**: This will be addressed via the implementation of the Pharmacy 7 day services business case, with the recruitment process now underway.
	✓ *Increase pharmacy prescribers to 70%*				**Progress update and risks to delivery**: Currently limited with prescribing pharmacists and above mentioned vacancies adding pressure to the department. **Mitigating actions**: Refinement and approval of additional prescribing pharmacist business case should allow metric to be green by the end of this financial year.
	✓ *Implement e-chemo prescribing system (October 2017)*				**Progress update and risks to delivery**: Resourcing and technology issues have been an issue however these are mostly resolved. **Mitigating actions**: Meetings are in process to agree implementation.
	✓ *Reduce number of patients with length of stay of 2 weeks or longer*				**Progress update and risks to delivery**: Work on the systematic management of 14 day length of stay continues. **Mitigating** actions include the implementation of red to green, introduction of an elderly care physician to support pre-operative optimisation and post-operative review.
Strategic aim four: be the place people choose to work					
➢ **Enhance colleague engagement**	✓ *Staff Survey embedded*	March 2018	Director of HR/ Chief Nurse		**Progress update and risks to delivery**: The survey takes place in October/November. Plans are in place to raise the profile and improve engagement across the Trust.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
✓ Develop a programme to enhance colleague engagement ✓ Embed the Staff Survey as a tool to help managers share best practice and make improvements to staff engagement	✓ *Improvement in the national Staff Survey engagement score to 3.8%*				**Progress update and risks to delivery**: The survey takes place in October/November. Plans are in place to raise the profile and improve engagement across the Trust.
	✓ *Increase the response rate to 48%*				**Progress update and risks to delivery**: The survey takes place in October/November. Plans are in place to raise the profile and improve engagement across the Trust.
	✓ *Extend staff Friend and Family Test update*				
	✓ *Staff story presented at Board*				
➢ **Maximise workforce capacity and capability, undertaking workforce redesign where appropriate**	✓ *Mandatory training target of 90% met be end of year*	March 2018		85%	**Progress update and risks to delivery**: A new policy has been developed **Mitigating actions:** supporting managers to understand and implement the policy on level one and two mandatory training
✓ Create an employee development programme underpinned by an employee training needs analysis	✓ *New roles in place i.e. Nursing Associate, clinical apprentice and nursing volunteers*				**Progress update and risks to delivery**: The Trust will work to develop clinical apprenticeships once the national training programme is agreed
✓ Create an Organisational Development Programme	✓ *Information Governance training target of 95% met by end of the year*			98%	**Progress update and risks to delivery**: **Mitigating actions:**
✓ Enhance mechanisms to identify potential to support succession planning	✓ *Employee development programme in place*				**Progress update and risks to delivery**: This is due in December 2017.
	✓ *Leadership Forum commenced*				**Progress update and risks to delivery**: This will commence in October 2017.
	✓ *Appraisal target of 90% met by end of year*			85%	**Progress update and risks to delivery**:

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
opportunities ✓ Improve performance against recruitment key performance indicators (KPIs) ✓ Boost staff retention through structured support ✓ Introduce new nursing roles					Managers are being supported to implement the new policy and appraisal forms.
	✓ *Recruitment and retention KPIs delivered*				**Progress update and risks to delivery**: KPIs have been developed and introduced
➢ **Maximise employee-well being** ✓ Improve workforce performance in sickness, mandatory training, appraisal ✓ Implement a smoke free site	✓ *Sickness absence target 3.5% met by end of year.*			3.9%	**Mitigating actions:** Managers are being supported to manage sickness absence and to apply the sickness absence policy
	✓ *Achieve 5% improvement in two of the 3 health & well-being staff survey questions*				**Progress update and risks to delivery**: The results of the survey will be available in March 2018.
	✓ *staff well-being events are held at least four times a year focusing on physical and mental health*				
	✓ *Site smoke free by January 2018*				**Progress update and risks to delivery**: A paper is being discussed at Trust Board in September 2017.
Strategic aim five: make the best use of what we have					
➢ **Implement the Digital Trust Programme**	✓ *Each phase of the Digital Trust plan delivered in line with project plan*	March 2018	Chief Information Officer		**Progress update and risks to delivery**: **Mitigating actions:**
	✓ *Proof of Concept Shared Record developed*	Sept 2017			**Progress update and risks to delivery**: August leave could delay delivery.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
✓ Implement the core foundation systems for the Digital Trust ✓ Deliver a Proof of Concept Shared Record between GP's and DGFT					
➢ **Match capacity to demand** ✓ Implement an operational demand/capacity management tool	✓ *Operational demand/capacity management tool implemented*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: Demand and capacity modelling has been completed but not embedded within services. **Mitigating actions**: Further work is being undertaken until demand managed and appropriate capacity in place.
➢ **Deliver the agreed financial plan** ✓ Set budgets that will achieve a £2.45 m surplus and monitor progress. ✓ Deliver CIP of £12.5m and a financial control target of £2.45m surplus ✓ Identify and target specific areas of efficiency as identified through the Model Hospital Portal	✓ *Budgets set that achieve a £2.5m surplus* ✓ *£12.5m CIP and a £2.45m surplus control total achieved*	March 2018	Director of Finance/ Director of Strategy & Business Planning		**Progress update and risks to delivery**: Q1 has been achieved through recurrent means, but a significant improvement is required for quarter 2 and beyond to achieve the total surplus. **Mitigating actions** include agency spend reduction plans, further capacity reductions, (perhaps linked to social care funding) and robust monitoring of existing plans. Progress pipeline schemes to ensure that there are contingency CIP schemes in place.
➢ **Develop a Clinical Strategy which ensures a**	✓ *Refreshed Clinical Strategy in place*	June 2017	Medical Director / Chief Nurse		**Progress update and risks to delivery**: The Clinical Strategy is in draft form following consultation with clinicians and managers from

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast	Risks to Delivery & Mitigating Actions
sustainable clinical organisation ✓ Engage clinical workforce in the development of the strategy ✓ Reflect the impact of external initiatives within the strategy (i.e. STP, BCA, MCP).					across the Trust. The draft reflects the potential impact of external initiatives. The draft strategy will be considered by Trust Board in August 2017.
Strategic aim six: deliver a viable future					
➢ **Play an active part in the STP arrangements in the Black Country and West Birmingham** ✓ Implement the Sustainability and Transformation Plan	✓ *STP implemented*	March 2018	Chief Executive		
➢ **Play a part in the implementation of the Black Country Alliance initiatives.** ✓ Deliver the aspirations of the BCA procurement work stream including the	✓ *Savings identified achieved*	March 2018	Chief Executive		
	✓ *BCA procurement work stream implemented*				
	✓ *Implement the Black Country Pathology Review*				**Progress update and risks to delivery**: The BCA pathology Review Business Case is due to be considered by August Board.
	✓ *Deliver identified pharmacy benefits*				**Progress update and risks to delivery**: Three projects are under way:

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Nationally Contracted Products Programme. ✓ Work in partnership to develop a model for delivery of Black Country Pathology Services ✓ Develop opportunities for pharmacy benefits across Black Country Trusts ✓ Maximise back office opportunities					• Pharmacy Aseptic Unit review and rationalisation – a paper has been produced to propose a review. • Medicines Safety – initial projects scoped by Chief Pharmacists to improve prescribing, dispensing and administration of high risk drugs. • Medicines administration Pharmacy Technician Project – each BCA Chief Pharmacist is meeting with exec leads to establish if pilots can be undertaken locally and then pool the learning to develop the posts.
	✓ *Back office opportunities identified and delivered*				**Progress update and risks to delivery**: opportunities are being identified and timescale for delivery is being developed.
✓ **Work proactively with BCHCare FT to become the provider of MCP services** ††	✓ *Bid developed and submitted*	March 2018	Chief Executive		**Progress update and risks to delivery**: The Trust has submitted its response to the Pre-qualification Questionnaire in conjunction with Birmingham Community Healthcare. The outcome will be known on 08/08/2017.
➢	✓ *Revised care pathways scoped*				
✓ Develop and submit a joint bid in conjunction with BCHCare Foundation Trust ✓ Support and engage staff in the change process ✓ Develop and implement revised care pathways	✓ *Bid successful*				**Progress update and risks to delivery**: Regular discussions weekly with GP collaborative have taken place throughout the PQQ and will continue through bidding process,
	✓ *Communications plan in place for staff*				
➢ **Develop the Trust's**	✓ *Establish clinics at Bewdley Medical*	March	Director of		**Progress update and risks to delivery**: An

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 RAG Q2, Q3 & Q4 Forecast				Risks to Delivery & Mitigating Actions
market share in the Wyre Forest ✓ Identify and exploit opportunities for increasing the Trust's market share in the Wyre Forest.	*Centre*	2018	Strategy & Business Planning					evidence-based business case for expansion of DGFT's activity in the Wyre Forest at Hume Street and Bewdley Medical Centre from Autumn 2017 was developed and submitted to Wyre Forest CCG Clinical Executive. Wyre Forest CCG do not wish to expand the number of clinics and will review this as part of contract negotiations for 2018/19. **Mitigating actions**: DGFT will participate fully in contract negotiations.
	✓ *Expand clinics located at Hume Street*							**Progress update and risks to delivery**: An evidence-based business case for expansion of DGFT's activity in the Wyre Forest at Hume Street and Bewdley Medical Centre from Autumn 2017 was developed and submitted to Wyre Forest CCG Clinical Executive. Wyre Forest CCG do not wish to expand the number of clinics and will review this as part of contract negotiations for 2018/19. **Mitigating actions**: DGFT will participate fully in contract negotiations.

NHS
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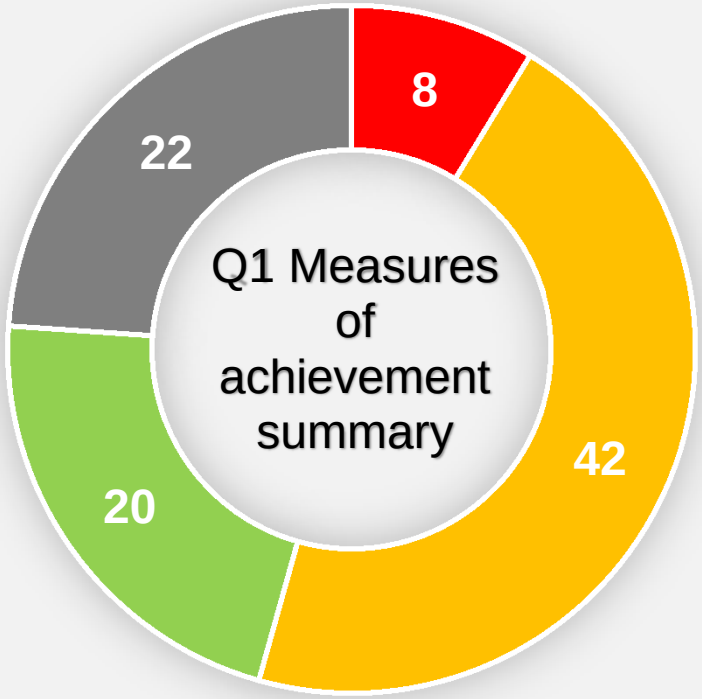
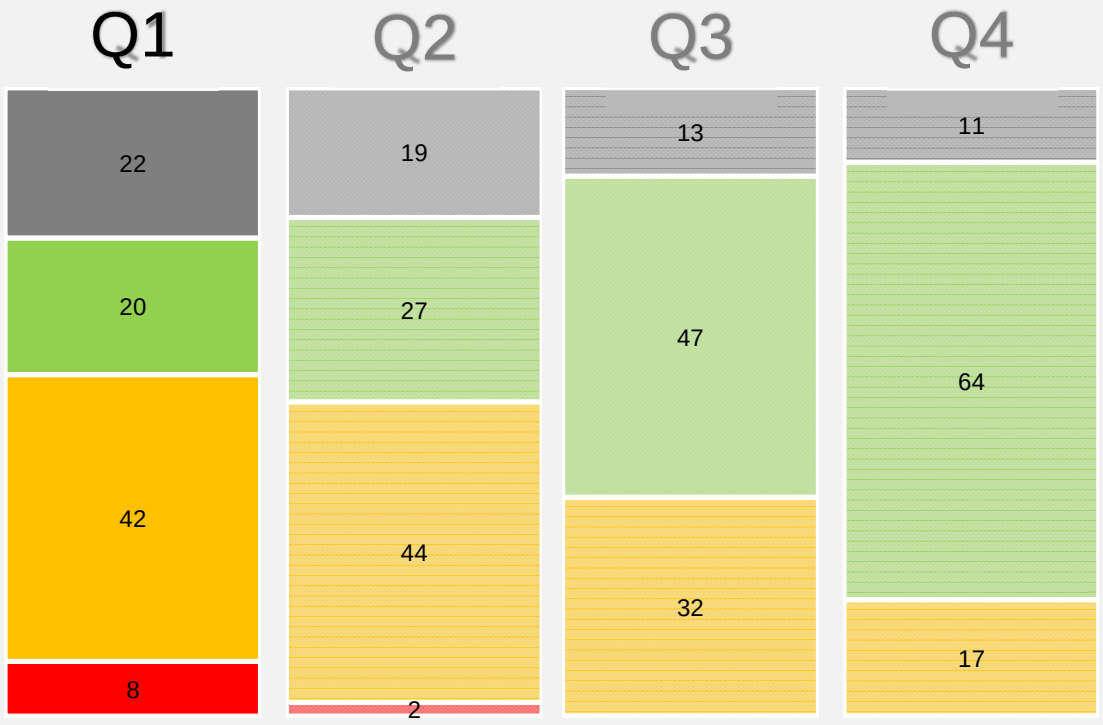
NHS Foundation Trust

OPERATIONAL PLAN PERFORMANCE

Q1 2017/18





1 Deliver a great patient experience

2 Deliver safe and caring services

3 Drive service improvement, innovation & transformation

4 Be the place people choose to work

5 Make the best use of what we have

6 Deliver a viable future

Enclosure 20

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board on 7th September 2017

TITLE:	**Smoke Free Site Proposal**		
AUTHOR:	**Andrew McMenemy, Director of Human Resources, Liz Abbiss Head of Communications**	**PRESENTER**	**Liz Abbiss Head of Communications**

CORPORATE OBJECTIVE:

SO3: **Drive service improvements, innovation and transformation**
SO4: **Be the place people choose to work**

KEY ISSUES:

National NHS Perspective

There is a growing expectation that NHS organisations will work towards implementing smoke free sites. In November 2016 this expectation escalated when Duncan Selbie, Chief Executive of Public Health England, highlighted that he would like more NHS organisation to provide smoke free sites. Alongside the enforcement of smoke free sites he also emphasised his encouragement to offer patients and staff support to give up their smoking habit.

NICE are also supporting a smoking ban on NHS premises by suggesting that Trusts should ensure "there are no designated smoking areas…"

There is now a ban on smoking in NHS organisations in Northern Ireland and in Scotland where legislation has been passed making it an offence to smoke on hospital grounds. Legislation is being prepared by the Welsh Assembly for possible introduction later this year.

According to PHE, smoking causes 96,000 deaths a year in the UK, and for each of those deaths, about 20 smokers are suffering from a smoking-related disease. About 475,000 hospital admissions in England were attributable to smoking in 2014-15, and the annual cost is estimated at £2bn, with a further £1.1bn in social care costs.

A recent report by the British Thoracic Society said 25% of hospital patients were recorded as being "current smokers" – which is higher than rates in the general population (19%).

Its other results included:

- One in 13 patients who smoke were referred to a hospital or smoking cessation service in the community;
- One in 16 healthcare institutions completely enforce smoke-free grounds;
- More than one in four patients were not asked if they smoked;
- Nearly three out of four smokers were not asked if they would like to quit smoking;
- 50% of frontline healthcare staff in hospitals were not offered training in smoking cessation.

The report concluded that within the NHS that there was “much to do to improve smoking cessation treatment for patients in hospitals across the UK”.

The Local Context

The Trust currently provides facilities for smoking shelters across the three main sites and therefore has not fully implemented being smoke free. The acute Trusts at Coventry & Warwickshire and Derby Hospitals have successfully implemented smoke free including the removal of smoking facilities.

We are aware that the Trust receives regular complaints associated to patients, visitors and staff smoking at the entrances to the hospital.

Proposal

The Trust enters a period of consultation with the public and staff to receive views on a proposal to go completely smoke free. This period of consultation took place using an electronic survey for all stakeholders alongside an event day where staff, patients and visitors were provided the opportunity to provide their feedback in a face to face forum at the Trust.

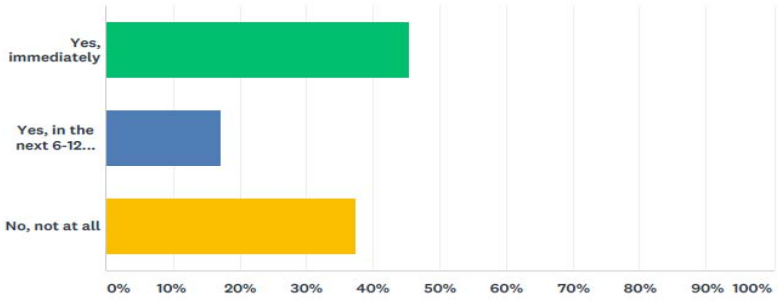
Feedback Results

The main results from the feedback survey provide that:
771 responses were received, over 81% of respondents work for the Dudley Group, our PFI partners or an organisation that works regularly with the Trust and just over 18% of responses were from patients. Over 28% (220) of responses were from smokers or e cigarette smokers with more than 71% (551) of responses from non-smokers.

When asked would you like to see our hospital sites go smoke free, including the removal of smoking shelters, 62.52% said yes immediately or yes, in the next 6-12 months and 37.48% said no not at all (see chart below). Of the smokers responses 13% said yes and over 86% said no not at all.

Q2 Would you like to see our hospital sites go smoke free, including the removal of smoking shelters?

Answered: 771 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes, immediately	45.40%	350
Yes, in the next 6-12 months	17.12%	132
No, not at all	37.48%	289
TOTAL		771

We also asked if the site were to go completely smoke free, would you expect to received support from the Dudley Group to stop smoking? 28.79% said yes they would.

Therefore it is concluded that the our staff, patients and visitors support the Trust in their plan to have the sites completely smoke free. In addition, the feedback also provides an indication that the Trust should also provide some support to assist in smokers quitting their habit as a way of demonstrating support during a period of significant change for some.

Recommendation

Taking consideration of the feedback from staff, patients and visitors it is recommended that the Trust Board concludes that Trust will become completely smoke free then a project plan and relevant resources will be agreed to support the smoke free changes. Taking consideration of the advice from Public Health England and Trusts that have successfully implemented smoke free, this resource would be focused on support for those wishing to give up their smoking habit. A case has been previously submitted to the Charitable Funds Committee to have two fixed-term posts approved for the purpose of supporting staff to give up smoking, in addition to the current resource in place to support patients. The final determination of the Committee was put on hold awaiting the recommendation of the Trust Board.

Conclusion

It is expected that NHS organisations will be required to be smoke free in the future and follow the example of Scotland, Northern Ireland and Wales. This is an opportunity for Dudley to determine its own future on this important issue and manage it appropriately and sensitively.

IMPLICATIONS OF PAPER:			
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Well Led**
	Monitor	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
Y	**N**	**Y**	**N**

RECOMMENDATIONS FOR THE BOARD:

To make a determination to go completely smoke free based on the consultation process and request that the Charitable Funds Committee approve the two posts to support smoking cessation for staff.

Enclosure 21

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board
September 2017

TITLE:	**Digital Trust Programme Committee update**		
AUTHOR:	**Mark Stanton CIO**	**PRESENTER**	**Ann Beck**

CORPORATE OBJECTIVE:

SO3: Drive service improvements, innovation and transformation
SO5: Make the best use of what we have

SUMMARY OF KEY ISSUES: ***(please identify key issues arising from report or minutes)***

A summary of the Digital Trust Programme Committee (DTPC) Meeting July 2017 (Note DTPC did not take place in August due to CQC visit)

1. **The Sunrise project is on-track against the project plan, excellent support from the Divisions for workshops continues**
2. **The Digital Communications plans has been agreed**
3. **The Device Strategy has been agreed**
4. **The process Initiation document has been approved**

IMPLICATIONS OF PAPER: (***Please complete risk and compliance details below)***

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/N**	**Details:** (***Please select from the list on the reverse of sheet)***
	Monitor	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

ACTION REQUIRED OF BOARD / COMMITTEE / GROUP: ***(Please tick or enter Y/N below)***

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE COMMITTEE

Demonstrate to the Board that the DTPC is providing governance for this project and note that a number of key milestone documents have been

approved

CORPORATE OBJECTIVES : *(Please select for inclusion on front sheet)*
SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO3: Drive service improvements, innovation and transformation
SO4: Be the place people choose to work
SO5: Make the best use of what we have
SO6: Plan for a viable future

CARE QUALITY COMMISSION CQC) : *(Please select for inclusion on front sheet)*	
Care Domain	**Description**
SAFE	**Are patients protected from abuse and avoidable harm**
EFFECTIVE	**Peoples care, treatment and support achieves food outcomes, promotes a good quality of life and is based on the best available evidence**
CARING	**Staff involve and that people with compassion, kindness, dignity and respect**
RESPONSIVE	**Services are organised so that they meet people's needs**
WELL LED	**The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture**

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Digital Trust Programme Committee	19th July 2017	Ann Becke	yes	no
			X	

Declarations of Interest Made

None

Assurances received

- Conformation was received that the Board approved the Population Health project to continue as long as no objections were received from Dr Simon Hughes who is the GP consortium IT lead. In a subsequent meeting Dr Hughes was comfortable with the project to continue. The project is on target for delivering the first 5 GP surgeries by October 2017
- Assurance was given that the Clinical approval group (CAG) had set out a number of points of principles regarding the management of results and data regarding the Point of Care Testing devices (POCT). They are also seeking assurances from the ROCHE team that a pragmatic training process is in place for Locum staff.
- The CAG confirmed that the changes to Soarian and Nervecentre are now implemented and approved to allow the Trust to migrate the ED Tracker to the NEWS score system. It was however noted that no request was made for an electronic version of the Sepsis screening document so this will continue as paper
- The performance indicators were noted and that they are now being owned by the division and reviewed at the appropriate Performance boards. IT have committed support to the Clinical services division to drive the 32% radiology orders up to 50% by October 2017.
- The overall project rating is Green and the project is still expected to deliver on time and on budget. Some of the sub-sections are amber rated due to delays in recruiting staff but all have mitigation in place.
- Engagement across the Trust for Digital Trust workshops has been excellent with all sessions having good representation across specialties.
- The IT projects group has now been set-up and will be chaired by Sarah Ellis, this group will give assurance on all project activity that falls outside the Digital Trust Programme. Main updates were around the completion of rolling out 4G Sim cards to Community and good progress on the NHSmail2 project.

Decisions Made / Items Approved

- The Sunrise Project initiation Document (PID) was presented to the group and approved
- The Marketing plan for the Digital Trust was presented and approved, the plan includes engagement events across the Trust taking us beyond the live date. It is expected that Allscripts will help fund some give-away items and some multi media such as large screens around the site.
- Shadow IT (IT staff working directly for Divisions outside of the control of Corporate IT) still needs to be resolved. Agreement has been reached for Pathology IT staff to transfer to Corporate IT, a plan is in discussion with ITU however Pharmacy still have a preference to recruit their own staff. This is being dealt with at a divisional level.
- The high-level Sunrise device strategy was presented and approved, this will include devices that suit the need of the job role and covers bedside mounted tablet devices and general wards computers. It was noted that project budget will cover the new types of devices such as bedside tablets but refresh of current ward PC's will need an additional funding as part of a re-fresh programmed.

Actions to come back to Committee (items Committee keeping an eye on)

- The committee will need to monitor the situation with the PC re-fresh that will be managed outside the project as Asset Lifecycle Management
- The committee will monitor the situation on Shadow IT

Items referred to the Board for decision or action

None

Comments relating to the DTPC from the CCIO

Excellent clinical engagement at all levels of the project so far:

- Current State Analysis – 50 sessions at departmental level
- Future State Design – 9 sessions attended by up to 50 clinicians from across all disciplines, reflecting key clinical pathways
- 15 SMEs in design streams
- Clinical representation at CAG and DTPC

Locum/agency process for POCT has now been approved, and is in keeping with Digital Trust Design Principles. Roll-out has begun